Richmond Surgery

Quality Report

Richmond Close
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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

We have rated the practice as requires improvement overall. Patients were positive about the services they had received from the practice. The practice provided caring and sympathetic, patient-centred care. Policies and procedures were in place for reporting concerns in relation to both adult and child protection issues. The practice monitored the quality of the service people received and was a training practice for student GP registrars. Our key findings were as follows:

- There were systems in place to ensure effective patient care and patients were satisfied with the services provided.
- Patients were cared for and treated with dignity and respect and staff ensured their privacy.
- Staff identified patients who needed additional support, and were pro-active in offering additional help.
- Patients were given enough time to discuss their concerns or treatments when they attended for appointments and that it was possible to book a double appointment when they needed to discuss more than one concern or complex problems.
- Significant events and complaints were investigated on an individual basis.
- The practice had a risk assessment policy but did not have a defined way to record risks and outcomes for the overarching governance of the whole practice.

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

Importantly, the provider must:

- Ensure medicines are kept securely and only accessible to authorised staff.
- Implement and monitor action plans that are in place following risk assessments being carried out. For example, fire safety and health and safety.

In addition the provider should:

Summary of findings

- Improve infection control with repair or replacement of the floor covering in one of the treatment rooms and devise a cleaning programme for the material curtains around examination couches.
- Risk assess security of reception back office for when the practice is closed.
- Ensure that all relevant recruitment checks are carried out for staff before they start to work at the practice.
- Review access requirements for disabled patients and make adjustments if required.
- Provide staff with training for the Mental Capacity Act 2005.

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 was rated as requires improvement for safe as there are areas where improvements should be made.

The practice used a number of sources of information and aimed to deliver safe care and treatment.

Infection prevention and control systems were in place and regular checks were carried out to ensure that all areas were clean and hygienic however staff training on infection control had not been carried out since 2012.

Appropriate arrangements were made in relation to obtaining medicines and vaccines. Controlled drugs were held securely. However medicines and vaccines that were kept in treatment rooms were not stored securely.

Emergency medicines and associated equipment was available.

A locum GP started to work at the service before relevant recruitment checks were carried out.

Emergency planning arrangements were set up with three other practices in the form of a local support business continuity plan for the service could still function in the event of an emergency.

Are services effective?

Good

The practice was rated as good for effective.

There were enough suitably trained and experienced staff to meet the needs of the patients who used the practice.

Staff demonstrated their understanding of the consent process the practice used.The practice worked with other healthcare providers and the practice held and participated in a number of multidisciplinary meetings with other health and social care professionals. A varied selection of information was available to patients about health promotion, ill health prevention and health related travel advice.

Are services caring?

Good

The practice was rated as good for caring.

Patients told us that they were always treated with dignity and respect when using the practice.

Summary of findings

Patients commented on how they were involved in their own care and had their care and treatment options explained to them.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive.

Patients could access the service when required.

Sufficient numbers of appointments were available, and patients could request telephone appointments or home visits.

Patients were supported with referrals to other health care providers and received results in a timely way.

Are services well-led?

Requires improvement

The practice was rated as requires improvement for well-led as there are areas where improvements should be made.

There were delegated responsibilities to named GPs, such as a lead for the safeguarding of vulnerable adults and children, a prescribing and a clinical governance lead.

Staff told us that there was an open and supportive culture at the practice. There were clinical monitoring systems in place and the practice improved as a result.

However, where health and safety risks were identified and action plans produced these were not implemented or monitored.

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.

The practice provided a personal service for patients who received palliative care.

Flexible appointments were available for seasonal flu and shingles vaccinations.

Patients who were house bound received home visits as appropriate. Patients who lived in a care home had a named GP who visited them weekly.

The practice identified patients who were at risk of hospital admissions and offered additional reviews. The practice also signposted patients to support groups such as Health Mind -Healthy Body, Time Out Café and the Dementia Friendly group.

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People with long term conditions

Good

The practice is rated as good for care of people with long term conditions.

Patients had a named GP and structured annual reviews to check that their health and medicine needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The review dates of patients with some long term conditions such as heart disease, chronic breathing problems and stroke were monitored.

Testing facilities for specific conditions were available at the practice which meant that results were immediately available and patients did not have to travel to the local hospital.

Families, children and young people

Good

The practice is rated as good for the care 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. For example, vulnerable children were discussed at regular meetings at the request of a health visitor.

Summary of findings

Staff knew how to recognise the signs of abuse in children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Appointments were available outside of school hours and the premises were suitable for children and babies.

There was joint working by the practice with midwives and health visitors.

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 care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. For example online appointment booking and cancelling facilities, early morning appointments (7.30 – 8am) and evening (6-8pm) surgeries were available three days a week.

Two Saturday flu vaccination clinics were available for patients who worked Monday to Friday.

Telephone consultations were also available with the GP or senior nurse for patients who could not attend the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances.

There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in patient's homes who found it difficult to attend the practice premises.

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

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults. 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 care 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 an in-house counselling service but also sign-posted patients experiencing poor mental health to NHS mental health support services and voluntary organisations.

The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. A GP and senior nurse had received training on how to care for people with dementia.

Summary of findings

What people who use the service say

We spoke with four patients and collected 13 comments cards during our inspection. Comments were almost all positive about the service provided. Patients described the service as caring and effective, and the staff as friendly and courteous. Comments about cleanliness and hygiene at the practice were also positive.

A patient survey was carried out in the last 12 months by the patient participation group. The survey showed high levels of patient satisfaction with the services provided. For example 83% of the 649 patients who responded said they would recommend the practice. A similar percentage (89%) of patients surveyed felt that were satisfied with care and services provided by the practice.

We saw the results of the survey had been made available to all patients on the practice website alongside the actions agreed as a result of the patient feedback.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines are kept securely and only accessible to authorised staff.
- Implement and monitor action plans that are in place following risk assessments being carried out. For example, fire safety and health and safety.

Action the service SHOULD take to improve

- Improve infection control with repair or replacement of the floor covering in one of the treatment rooms and devise a cleaning programme for the material curtains around examination couches.
- Risk assess security of reception back office for when the practice is closed.
- Ensure that all relevant recruitment checks are carried out for staff before they start to work at the practice.
- Review access requirements for disabled patients and make adjustments as required.
- Provide staff with training for the Mental Capacity Act 2005.

Richmond 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 specialist advisor.

Background to Richmond Surgery

Richmond Surgery is situated in Richmond Close, Fleet, Hampshire and shares its premises with a pharmacy.

The practice is responsible for providing services to approximately 12,500 patients who live in Fleet, South of the Canal, Church Crookham and Crookham Village.

Appointments are available between the 8 am and 6.30 pm on weekdays. The practice also provides an early morning commuter clinic from 7.30am to 8am on a Monday, Thursday and Friday and an evening commuter clinic from 6.30pm to 8pm on a Tuesday, Wednesday and Thursday.

The practice has opted out of providing Out-of-Hours services to their own patients and refers them to another provider.

The mix of patients' male to female is almost equal. Approximately 2,300 of patients are aged over 65 years old and at the time of inspection 93 of these live in care homes. The practice also has about 800 patients who are under five years old.

The practice has four full time GP partners. Two are male and two are female GPs.

The GPs are supported by a specialist nurse and two practice nurses, a health care assistant and a phlebotomist (phlebotomists are medical technicians who are trained to take blood samples from patients).

GPs and nursing staff are supported by a team of 10 receptionists and a reception manager. The practice also has an administration team which consists of two medical secretaries, three administrators and the practice and business manager.

Richmond Surgery is a GP training practice for medical students who study at both Imperial College London and the University of Southampton.

We carried out our inspection at the practice's only location which is situated at;

Richmond Surgery

Richmond Close

Fleet

Hampshire

GU52 7US

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection was carried out on 15 October 2014 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the provider to send us some information about their practice before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices.

We carried out an announced visit on 15 October 2014. During our visit we spoke with 14 staff which included GPs, nursing and clinical staff, receptionists, administrators, secretaries and the practice manager.

We reviewed 13 comment cards where patients and members of the public shared their views and experiences of the practice during our visit. We also spoke with four patients who used the practice.

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:

- 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)

Richmond surgery's population profile is slightly higher than the England average for patients aged 35 to 49. However the practice is situated within commuting distance to London and serves a large working age population.

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, reported incidents, National Patient Safety Alerts (NPSA) as well as comments and complaints received from patients. The practice managed these consistently over time and could evidence a safe track record over the long term. For example, a situation occurred when an incorrect sample bottle was used for a urine specimen that required laboratory tests. This was reported appropriately and minutes of a meeting which followed this showed that the issue was discussed with relevant staff and a new system initiated as a result. Staff were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 24 months and these were made available to us.

We tracked incidents and saw records were completed in a comprehensive and timely manner. There was evidence of action taken for example, a patient who lived in a care home had it noted in their notes that they were allergic to penicillin. A prescription for penicillin was issued to this patient. The error was raised with staff by a relative and an investigation was carried out which involved a GP updating all the notes of patients who lived in care homes. A system was then put in place to prevent a repeat error.

A dedicated meeting took place every week that included significant events. This was attended by GPs and appropriate staff. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

NPSA alerts were disseminated to the GPs and practice staff as appropriate by the practice manager who showed us a number of examples. Evidence to show these had been read was seen. We were told that whilst locum GPs were invited to attend practice meetings they were not always able due to other commitments. The practice manager told us that minutes were always available and locums were encouraged to view these.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. Three of the four partner GPs had received level three safeguarding training. The practice could not confirm if the locum GP had completed the training and to which level.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a dedicated GP who was appointed as lead in safeguarding vulnerable adults and children and had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and promoted on the waiting area noticeboard, newsletter and website. Chaperone training had been undertaken by two reception staff who understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. A patient commented about the lack of male chaperones and was told that the practice did not have any male administration staff but they could request to see a GP of the same gender as required.

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

Requires improvement

Are services safe?

The lead safeguarding GP was aware of which patients were vulnerable, and records confirmed good communication was in place with partner agencies. For example, health visitors and GPs had regular meetings for which records confirmed that vulnerable children were discussed.

Medicines Management

We checked medicines that were stored in treatment rooms and medicine refrigerators and we found that the rooms were secure. However, drawers that contained medicines were not locked which made them accessible to any staff that had access to the rooms.

Records confirmed that vaccines and medicines were stored within a safe temperature range of between two and eight degrees Celsius. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Records confirmed that checks of the expiry date and availability of emergency medicines and equipment were carried out monthly. However, we found three syringes had passed their use by dates which indicated that checks on the expiry date and availability of emergency equipment did not follow current Resuscitation Council (UK) guidelines for primary care services. Three out of date syringes were however immediately replaced.

Vaccines such as for flu and shingles were administered by staff that were appropriately trained and processes followed national guidelines. Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. For example, batch numbers of prescriptions that were delivered to the practice were logged.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed by GPs.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of the potential for misuse). Standard procedures were in place that set out how they were managed. Controlled drugs were stored in a controlled drugs cupboard and access was restricted to authorised staff and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. Cleaning schedules in place for the cleaners and cleaning records were kept.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these in order to comply with the practice infection control policy. This included waste management procedures. There was also a policy in the event of a needle stick injury.

The lead nurse was the lead for infection control. They told us that all staff received induction training about infection control specific to their role and then received annual training updates. However, we found that training had not been carried out by any practice staff since 2012.

Infection control audits were seen for the last three years and any improvements identified for action were completed on time. However, we noted one of the treatment room floors had floor covering missing in places. Also, material curtains were used in the treatment and consulting rooms but a cleaning programme was not in place to identify the type and frequency of cleaning required to minimise the risk of cross infection.

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

A health and safety audit, that was carried out in March 2014, recommended that a legionella risk assessment should be carried out but this was not implemented. Legionella is a bacteria found in the environment which can contaminate water systems in buildings.

Equipment

Staff 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 annually and we saw equipment maintenance logs and other records that confirmed this. For example, all portable electrical equipment had been tested in March 2013.

We also saw evidence of servicing and calibration of relevant equipment had taken place in May 2014. Items tested included, blood pressure monitors, defibrillator and baby scales.

Staffing & Recruitment

The practice did not have a recruitment policy or training strategy. We were told by the practice manager that they knew what to look for on recruitment and went on to describe the checks they would undertake for a nurse, and an administrator.

Newly appointed staff carried out induction training which included equality and diversity, health and safety, fire safety and information governance.

We looked at three staff records. Two contained evidence that appropriate recruitment checks had been carried out prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

The third record was for a locum GP (a locum GP is a GP who temporarily fulfils the duties of another GP). We were shown the recruitment record for this locum and found there was missing information which included evidence of a full employment history, evidence of satisfactory conduct in previous employment, qualifications and proof of identity.

Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. Teams included GPs, reception, administration, nursing and each had a manager/lead. A rota system was in place for all the different teams to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. We saw an administrator working on reception on the day of our visit and was told they split their hours this way to cover each team.

Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

There were formal risk management processes in place for checks of the building, environment and fire safety. For example, we saw work station risk assessments which had been carried out in May 2014. We were told that as a result of the assessment nine new chairs were purchased for staff.We were told that there was a close circuit recording (CCTV) system installed, outside and in the public areas of the building. This was in response to the onsite pharmacy being open outside surgery hours. We saw signage outside the practice, on the website and in newsletters for patients and visitors the practice also had a responsibility to advise the Information Commissioner that recordings were being made but had not done so. The practice shared access to recordings from the CCTV with the independent pharmacy located in the building. We were shown a confidentiality policy for visitors to the building but there was not a formal information sharing policy between the pharmacy and practice.

We saw a quiet room situated next to the reception desk which we were told was used for private conversations between patients and staff. The door to this room was not lockable which compromised the security of the reception and back office both during and out of practice opening hours. A partner GP told us this was being addressed as the door was recently installed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

Emergency medicines and equipment were available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked monthly. All the emergency medicines we checked were in date and fit for use.

Risks to the practice included power failure, adverse weather, unplanned sickness and access to the building.

Requires improvement

Are services safe?

The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken in March 2014 that included actions required to maintain fire safety. One action required was training for the person responsible for fire safety. We were told this and other actions had not been addressed.

Mutual emergency support arrangements with three other local GP practices were set up by way of a local support business continuity plan. The plan contained information about staffing, services, communication, administration and logistics which could be accessed by any of the four practices in the scheme.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff outlined the rationale for their treatment approaches. They were familiar with current best practice guidance by accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Information reviewed confirmed that each patient was given support to achieve the best health outcome.

A GP told us they kept a diary of information they obtained from different sources such as health publications and reported back to the practice at weekly meetings. We saw evidence that guidelines were disseminated to appropriate staff, the implications for the practice's performance and patients were discussed and required actions agreed.

The GPs had lead roles in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work.

National data showed the practice was mostly in line with referral rates to secondary and other community care services for all conditions. An area which needed improvement was reporting of patients on the dementia register. GPs were aware of this and addressed this by reviewing all patients who were on the dementia register and referred those who required a CT scan. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practise were shared with appropriate staff.

Interviews with GPs and staff showed that the culture in the practice was that patients were referred on need and not adversely influenced by patient age, gender and race.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included about osteoporosis, minor surgery and prescribing data.

One GP carried out minor surgical procedures in line with their registration and NICE guidance and carried out clinical audits for example, mole removal. The practice reviewed procedures in relation as a result of medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. An example of an audit showed practice had not achieved the highest targets nationally for diabetic care but it compared well with the other local practices in the clinical commissioning group (CCG).

Other audits carried out locally showed that diabetic complication rates were very low both in the CCG and this practice. Another example seen was the prescribing of statins for patients who needed to reduce their cholesterol levels. Following the audit the GPs carried out medication reviews with patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with mandatory training such as annual basic life support. Records confirmed that 18 of the 26 staff had received training in basic life support in July 2014.

All GPs were up to date with their yearly continuing professional development requirements and all had either 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).

All staff received annual appraisals which identified learning needs and these were documented. Staff confirmed that the practice was proactive in providing training. For example, GPs and nursing staff had completed courses in respiratory disease and asthma.

The practice was also a training practice and had up to three qualified doctors in education posts at any one time. Practice GPs attended regular GP teacher training to support this.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to

Good

Are services effective?

(for example, treatment is effective)

fulfil these duties. For example, a practice nurse who administered travel vaccines attended training for this in March 2014. Those with extended roles such as diabetes care were also able to demonstrate they had appropriate training to fulfil these roles. Records confirmed that diabetic care training was carried out in January and February 2014.

Working with colleagues and other services

Staff worked with other health and social care providers to deliver effective care. For example, GPs had direct access to hospital consultants by telephone which they said avoided unnecessary hospital admissions.

The practice held multi-disciplinary team meetings every eight weeks which district nurses, health visitors, practice nurses and GPs attended. The practice was awarded the Gold Standard Framework and records of meetings for end of life care showed involvement of district nurses, health visitors and McMillan hospice nurses.

The practice worked with other service providers to meet patients complex care needs. Blood results, x ray results, letters from the local hospital including discharge summaries, out of hours providers and other services were received both electronically and by post.

The practice shared key information with the Out of Hours (OOH) service about patients nearing the end of their lives, particularly information in relation to decisions that had been made about resuscitation in a medical emergency.

The practice had a system for sharing information and taking action any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles.

Information Sharing

The practice used email and phone to communicate with other health care services. We were told that a system was being considered to enable the practice to share patient data with the OOH service. Electronic systems for making referrals were seen and the practice made use of these.

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 patients' care. All staff were trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it although they said they had not received any formal training.

Staff demonstrated their understanding of consent and that patients had the right to withdraw it at any time and that this would be respected.

Where patients did not have the capacity to consent to treatment, staff were able to demonstrate that they acted in accordance with legal requirements. Mental capacity is the ability to make an informed decision based on understanding the options available and the consequences of decisions made. If patients were unable to make a decision for themselves, staff told us that they involved relatives to support patients in their treatment options.

We saw that there was a consent policy in place which showed that consent would be either implied or would be asked for and then it would be recorded.

Patients whose first language was not English would be asked for their consent to allow staff to discuss their care with a relative or advocate who could speak English. This consent was recorded in the patient's record

Health Promotion & Prevention

We saw that the practice had a range of printed information available in the reception area relating to the promotion of good health and the prevention of ill-health, such as information about smoking cessation, diet advice and allergies. Information was also available on the practice website. For example, dates of flu and shingles vaccination clinics.

All new patients registering with the practice were offered a health check with the health care assistant or practice

Good

Are services effective?

(for example, treatment is effective)

nurse. This check included height, weight and blood pressure level together with a urine test. GPs were informed of all health concerns detected and these were followed-up in a timely manner. For example, a patient identified as having high blood pressure (hypertension) would be followed up by the GP.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 5% of patients in this age group took up the offer of the health check in 2013.

Staff told us that none of the 23 patients who had learning disabilities had their care plans reviewed in 2013 but they had since signed up to the learning disability enhanced service and would start patient reviews once training was carried out and a clinic set implemented.

Cervical smears were offered via a national NHS computerised recall system. The practice's performance for cervical smear uptake was 85% in 2013 which was better than others in the CCG area. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Last year's performance for all immunisations of two year olds was 93% and there was a process for following up non-attenders.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

CQC comment cards to provide us with feedback about the practice were completed by 13 patients. The majority were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Two comments were less positive but there were no common themes to these. We also spoke with four patients on the day of our inspection who all told us they were satisfied with the care and respect provided by GPs and staff at the practice.

There was a glass screen between the reception desk and waiting area which improved patient's privacy when speaking to reception staff.

Consultations and treatments were carried out in the privacy of separate rooms. Curtains were provided in these rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy which we were told all staff had signed when they started to work at the practice. We looked at three staff recruitment records which confirmed this. We observed staff following the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

The practice switchboard was located away from the reception desk and was shielded by patient notes cabinets which helped keep patient information private. However, staff working at the pharmacy had access to this area which may compromise patient confidentiality.

We were told that patients were offered a quiet room should they wish to speak to reception staff in private and noted the room beside the reception desk. This room was small and not accessible to a wheelchair user without furniture being removed first.

Whilst the room had a door on it leading to the public side of the reception area there was not a door to the administration side of the reception desk which allowed staff from the pharmacy to overhear conversations should they be near the reception desk.

In response to patient survey carried out by the practice patient participation group, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between a patient and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

A chaperone service was available and promoted. Information about this service was displayed in the patient waiting area, website and practice newsletter. Two reception staff had trained as chaperones and both had criminal record r checks and were aware of their role and responsibilities.

Care planning and involvement in decisions about care and treatment

GP patient survey information we reviewed showed 65% of the patients who completed the survey rated the practice well when asked about their involvement in planning and making decisions about their care and treatment. Whilst 74% felt the GP was good at explaining treatment and results. Both of these results were below average compared to CCG area average.

However, patients told us that they were given enough time to discuss their concerns or treatments when they attended for appointments and that it was possible to book a double appointment when they needed to discuss more than one concern or complex problems.

Patients told us that when they needed to be referred to another service or specialist this was discussed during their appointment. Of the patients referred since April 2014 20% used the Choose and Book service (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic).

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and practice website signposted people to a number of support groups and organisations. The practice's computer system

Good

Are services caring?

alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. For example bereavement or counselling services.

GPs were aware of these services and told us they signposted patients appropriately. GPs held their own patient lists and once they were informed of patient's death informal arrangements were made to support their relative/family.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice maintained links with local area commissioners and we were told meetings took place bi-monthly to review and plan how the practice would continue to meet the needs of the patients and potential service demands in the future.

The practice worked closely with community teams, including district nurses and health visitors. Patients said they were referred promptly to other services for treatment and test results were available quickly. Staff explained that a range of services and clinics were available to support and meet the needs of different patient groups and that they would refer patients to community specialists or clinics as appropriate. For example, referring parents with babies and young children to the community health visitor.

The practice had systems in place to seek and act upon feedback from patients. The practice promoted its patient participation group which was made up of practice staff and patients that represented the patient population.

Tackling inequity and promoting equality

The practice provided all new staff with equality and diversity training during their induction.

We were told that the practice had recognised the needs of different groups in the planning of its services. However, we found that the building was not fully accessible to wheelchair users. For example, the reception desk was high and out of reach of a wheelchair user.

A patient toilet was available but staff confirmed this was not accessible for a wheelchair user due to its small size. We were told that planning permission had been granted to extend the building.

We asked staff about how they met the needs of people whose first language was not English. There was not a translation service available (e.g. language line for non-English speakers).They also said that there were no formal systems in place to support disabled patients. However, we were told how staff supported patients with hearing difficulties where the speaker system may not be heard that the GP would advise reception staff of the request for the patient and then the patient could be spoken with directly.

Access to the service

The practice worked towards ensuring patients could book appointments at a time to suit them. GP patient survey information we reviewed showed 95% of the patients who responded said their last appointment was at a convenient time. This result was above average compared to the clinical commissioning group area average.

The practice opened extended opening hours which were Monday, Thursday and Friday 7.30am to 8am and Tuesday, Wednesday and Thursday 6pm to 8pm which gave patients the opportunity to attend either before or after work.

Patients told us that they could always get an appointment when they needed one. Patients could make appointments four to six weeks in advance with their registered GP. A number of emergency book on the day appointments were also available. If the book on the day appointments were full and patients needed medical advice, they were offered a telephone consultation with their GP or a nurse.Appointments both in advance and on the day were also available weekday mornings (excluding Wednesday) for the senior nurse's minor illness clinic.

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

There were also arrangements in place for patients who needed urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients.

Listening and learning from concerns & complaints

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

The practice took steps to make patients aware of the complaints system. There was information in the practice leaflet, the waiting area and on the practice website to alert patients to the comments and complaints process.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the practice complaints policy and procedures. The policy detailed the timescales for responding to any complaint received. We were told the timescale was three days to respond. Contact details of who to complain to if the patient was not satisfied with the response to their complaint was seen on the practice website.

Staff knew their responsibilities in the event of a complaint being received. We looked at the complaints the practice had received this year and saw that the complaints procedure had been followed and that issues had been raised directly with the GP concerned.

Patient complaints were discussed at GP partners meetings and learning points shared with staff. Patients told us that they had not had any reasons 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

The management team at the practice told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams.

The GPs were partners and shared responsibility in the working arrangements and commitment to the practice.

The practice were in the process of extending the premises for which planning permission had been sought. We were told that whilst the practice did not have a formal business plan it was reacting to patient demands and the building work was a result of this.

Staff said that there was a good sense of team work within their particular department and communication worked well throughout the practice but the whole practice team ethos was missing.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at six policies and procedures. All had been reviewed in the past 12 months. For example, the staff handbook and risk assessment policy.

The practice held governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it compared favourably with other GP practices locally. We saw that QOF data was regularly discussed at GPs meetings and action plans were produced to maintain or improve outcomes. An area which the practice could improve was in dementia care. This was addressed by the GP who was the dementia lead who reviewed the notes of all the patients on the dementia register to ensure they were up to date and reflected patient's needs.

The practice had completed a number of clinical audits to review the quality of the service, for example prescribing medicines for patients who had osteoporosis.

The practice had a risk assessment policy but did not have a defined way to record risks and outcomes for an overarching governance of the whole practice. Systems were not in place to manage the action plans that were in place following risk assessments.

Leadership, openness and transparency

There was a staff handbook available for all staff which listed every member of staff and the department they worked in. The handbook included sections on bullying and harassment and stress at work. We spoke with ten members of staff and they were all clear about their own roles and responsibilities.

Staff told us they felt valued, well supported by their colleagues and line managers and knew who to go to in the practice with any concerns. Staff told us the practice manager was available for them as needed. There were named members of staff in lead roles. There was a lead nurse for infection control and the senior partner was the lead for safeguarding. The practice manager was responsible for human resource policies and procedures.We were told that department team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were able to raise issues at these meetings.

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

The practice had an active patient participation group (PPG) which was used by the practice. The PPG met every six to eight weeks and used the feedback from patients to help the practice learn and improve. The PPG told us that they felt involved in the service and the practice's senior management engaged with the group positively and acted on patient feedback.

The practice also had a group of approximately 6,500 patients known as a virtual patient reference group (VPRG). The VPRG was contacted from time to time by the PPG to complete patient surveys. Surveys covered areas such as opening hours, patient information, availability of appointments and telephone access. Feedback from a previous survey indicated that patients were unhappy with nurse waiting times. As a result the practice employed another practice nurse to address this.

Are services well-led?

Requires improvement

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

We saw that the practice responded to issues or concerns raised by patients in a positive way. We looked at the most recent VPRG patient satisfaction survey and there were 649 patient responses.

From this survey patients had said that they wanted better access to the practice by phone. This was responded to and a telephone queuing system was installed and seen to be working during our inspection. The results of all the VPRG surveys carried out since the PPG started were published on the practice website.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Records confirmed that annual staff appraisals took place.

Staff told us that the practice was very supportive of training but would value a more structured supervision programme between annual appraisals.

The practice was a GP training practice and had links with two universities and GPs that were involved in this attended regular training to ensure their own skills were up to date.

The practice took account of complaints to improve the service and significant events were discussed and learnt from through regular quality meetings. However, there was no system in place to review significant events.
This omission was confirmed by the practice manager who agreed that a system was required to ensure the practice improved outcomes for patients.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person must –** **Make appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.** **Medicines kept in a treatment room were stored in drawers that were not locked. Unauthorised staff and external cleaners could access these.**

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 **The registered person must –** **(2) (iv) Have regard to appropriate professional and expert advice.** **A fire risk assessment was carried out by an external specialist company in March 2014. An action plan resulting from this assessment was not implemented.** **A health and safety audit, that was carried out in March 2014, recommended that a legionella risk assessment should be carried out but this was not implemented.**