Fleet Medical Centre

Quality Report

Fleet Medical Centre
Church Road
Fleet
Hampshire GU51 4PE
Tel: 01252 613327
Website: www.fleetmedicalcentre.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of this service on 2 October 2014.

We have rated the practice as good overall.

The practice delivered effective care and treatment to its patients. There was a clear vision and strategy which outlined planning objectives for the sustainability of the service in the future. Staff took an active role in the planning and delivery of the service. We saw a clear and simple management structure in place and monitored which supported the service to run smoothly.

Our key findings were as follows:

- The practice was clean, well maintained and there were systems in place to maintain appropriate standards of cleanliness and hygiene.
- Patient's access requirements were taken into account when services were planned and delivered. These included availability of appointments outside working hours and physical access for disabled patients.
- Patients rated the practice above the regional average for ability to get an appointment to see or speak to someone, their confidence with nursing staff and being given enough time for their nurse appointments.
- GPs and nurses received appropriate training and professional development supervision and training.
- The practice regularly assessed and monitored the quality of its services and actions were taken to improve when necessary.

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

Importantly, the provider must:

- Ensure that relevant checks are carried out for staff prior to employment.
- Ensure medical emergency equipment is available and fit for purpose (within use by date).

In addition the provider should:

Summary of findings

- Ensure relevant staff know what action to take in the event of a potential failure in the cold chain in relation to the safe storage of medicines (for example, a fridge breakdown).

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.

The practice used a number of sources of information and aimed to deliver safe care and treatment. There was a system in place for reporting, recording and monitoring significant events. Infection prevention and control systems were in place and regular audits were carried out to ensure that all areas were clean and hygienic.

Appropriate arrangements were made in relation to obtaining medicines and vaccines. Controlled drugs were held securely in a specifically designed cabinet.

Emergency medicines and associated equipment was available. However, checks on the expiry dates of emergency equipment was not monitored.

The practice had a recruitment policy which detailed the recruitment checks to be undertaken before a person started to work there. For permanent staff, files were comprehensive and complete, however, checks for locum GPs did not follow the practice's policy for recruitment checks.

Emergency planning arrangements were set up with three other surgeries locally in the form of a local support business continuity plan which ensured the service could still function in an emergency.

Are services effective?

Good

The practice was rated as good for effective. There were procedures in place to ensure that care and treatment was delivered in line with best practice standards and guidelines, for example the diagnosis of hypertension (high blood pressure).

Staffing levels were suitable for the number of patients registered at the service.

Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatment they needed in a timely manner.

Are services caring?

Good

The practice was rated as good for caring.

The patients we spoke with and the comment cards we reviewed were mostly positive about the care provided.

Summary of findings

Patients told us that the staff were kind and caring. They told us the GPs always treated them with respect and explained their treatment in a way they could understand.

While the area has a very low percentage of people whose first language was not English patients had access to interpreting services.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive to patient's needs.

There were sustainable systems in place to maintain the level of service provided.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The practice had a system in place for handling complaints and concerns, was proactive in seeking the views of patients and responded to their suggestions to improve the service.

Are services well-led?

Good

The practice was rated as good for well-led.

The practice had a clear vision and strategy and followed its business plan which outlined plans for future planning.

Effective governance arrangements were in place and staff were aware of their own roles and responsibilities.

Staff performance and professional development was managed effectively.

Leadership was visible and accessible to staff and patients. The practice had an active patient participation group which was used effectively to feedback patient views to improve outcomes.

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 was rated as good for the care of older people.

Automated flu and shingles vaccination reminders were sent to patients and followed up if they did not attend.

Patients aged 75 and over had a named GP. Those in this age range who lived at a care/nursing home were visited every week by their named GP.

The practice had level access throughout.

There were chairs placed half way in long corridors as a resting point. Staff told us they would call an older patient early for their appointment so they could take a rest before they reached their treatment room.

People with long term conditions

Good

The practice was rated as good for the treatment of people with long term conditions.

Patients who had established angina or a history of a heart attack were invited to attend a clinic run by practice nurses with specific training. Their blood results, diet, lifestyle and medication was discussed. The clinic helped patients to increase their healthy living awareness and gave them an opportunity to discuss any concerns or management issues they had.

Regular dedicated diabetes clinics were run by the GP and nurse teams for patients who were newly diagnosed or were established diabetics. This GP also held a separate clinic once a week to review patients who had particular difficulties controlling their blood sugar levels. Complex diabetes clinics were also run by this GP in order to reduce the need for patients to travel to secondary care settings such as a local hospital.

Injectable therapies, such as those for patients with diabetes or rheumatoid arthritis, were also managed by staff at the practice.

Families, children and young people

Good

The practice was rated 'good' for the care of families, children and young people.

Advice and support for expectant and post natal mothers was provided by the local midwifery team who were based at the practice. Mother and baby clinics and health checks were available with the mother's named GP at baby's sixth week.

Summary of findings

Vaccinations were also given at these clinics. Midwives and health visitors attended regular practice meetings to discuss patients in their care.

Staff we spoke with were aware of the Gillick competence when asked about treating teenage patients. Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge.

Chlamydia (sexually transmitted infection) testing packs were available from GP/nurse but also placed in patient washrooms to increase uptake without embarrassment. The practice also offered contraception services including coil fitting, implants and family planning services.

Working age people (including those recently retired and students)

Good

The practice was rated 'good' for the care of working age people (including those recently retired and students).

The practice operated extended opening hours on a Monday (8am to 8pm) and every fourth Saturday (8am to 11am). The practice also held an over spill surgery at lunchtime every day for patients to book on the day appointments.

There was a range of ways to contact the practice. These included appointments over the telephone and on-line repeat prescription request and appointment booking service.

People whose circumstances may make them vulnerable

Good

The practice was rated ‘good’ for the care of people living in vulnerable circumstances.

The practice made appointments immediately available for people who were not registered patients and required urgent medical treatment (for example, homeless people).

GPs made home visits to patients who were not able to attend the practice.

Weekly visits in the form of ward rounds were carried out to people who lived at care/nursing homes.

Patients who had a learning disability had their health reviewed every year by their named GP.

The practice oversaw the care of some young mothers/ babies who resided in a protective environment.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice was rated 'good' for the care of people experiencing poor mental health (including dementia).

Patient notes indicated the additional support any patient may need when attending the practice for an appointment and arrangements were made to offer longer appointments at the end of the surgery session. Also home visits were carried out when appropriate.

Special notes on patient's records showed where an 'appropriate adult' could be involved in this patient's care and treatment.

The practice had a nominated GP who was the safeguarding lead for vulnerable adults and children.

Summary of findings

What people who use the service say

We spoke with 11 patients on the day of our inspection. Nine were very positive about their experiences of care and treatment at the practice.

All the patients told us that their treatment was clearly explained to them and they were able to ask questions and make choices about their treatment or medicine.

Patients said they felt that there were enough staff and that staff had the right skills and experience to meet their needs. One told us that they had received care from professionals and another said the staff were good and they had all their needs met.

We received three comment cards on the day of our inspection. All the comments were positive and told us that the practice was caring and compassionate.

We reviewed data from the national patient survey which showed the practice was rated above the national average by patients who were asked if they were given enough time during their appointment by clinicians and their confidence and trust in the last nurse they saw and 84% of patients asked said they would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that relevant checks are carried out for staff prior to employment.
- Ensure medical emergency equipment is available and fit for purpose (within use by date).

Action the service SHOULD take to improve

- Ensure relevant staff know what action to take in the event of a potential failure in the cold chain in relation to the safe storage of medicines (for example, a fridge breakdown).

Fleet Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and two additional CQC inspectors.

Background to Fleet Medical Centre

Fleet Medical Centre is situated in Church Road, Fleet, Hampshire. The practice is located a short distance from Fleet town centre and a London main line railway station.

The practice has a higher number of patients aged between 35 and 50 and 65 and over when compared to the England average.

The practice shares the building with an independent dental service and pharmacy.

The practice is responsible for providing services to approximately 14,750 patients. Opening hours are 8am to 8pm Mondays and 8am to 6.30pm Tuesday to Friday. The practice also offers patient appointments every fourth Saturday.

The practice is registered to provide the following regulated activities:

- Diagnostic and screening procedures;
- Family planning;
- Maternity and Midwifery services;
- Surgical procedures; and
- Treatment of disease, disorder or injury.

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

The mix of patient's gender (male/female) is almost half and half. Approximately 20% of patients are aged over 65 years old and 106 patients live in nursing or care homes.

The practice has five GP partners and four salaried GPs who together work an equivalent of seven and a quarter full time staff. In total there are three male and six female GPs.

The practice also has a nurse practitioner (a nurse practitioner is a registered nurse who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse role).

The GPs and the nurse practitioner are supported by three nursing sisters, two nurses, two health care assistants and a phlebotomist (phlebotomists are staff who are trained to take blood samples from patients).

GPs and nursing staff are supported by a team of 14 receptionists and a reception manager. The practice also has an administration team which consists of two secretaries, three administrators, four data recording and technical staff and the practice and business manager.

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

Fleet Medical Centre

Church Road

Fleet

Hampshire

GU51 4PE

Detailed findings

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 2 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.

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 practice to send us some information 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.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with 12 patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

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

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

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

- 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)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used information gathered both externally and internally to identify risks and improve quality in relation to patient safety.

We saw records to show that medicine alerts received from external bodies such as the Medicines and Healthcare Regulatory Agency (MHRA) were shared appropriately with staff. Information also included reported incidents, national patient safety alerts as well as comments and complaints received from patients.

An example of a patient safety alert about home glucose monitoring equipment was also seen in the patient waiting area. All the staff we spoke with demonstrated an understanding of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a safeguarding concern.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This 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 a system in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred. We saw those created during the last 24 months.

A slot for significant events was included on the practice quality meeting agenda and records of these confirmed significance events were discussed. Records confirmed that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, an error occurred with the process staff followed for receiving urine samples. Staff discussed this and notice was placed in the sluice room to prevent this happening again.

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.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy and a named safeguarding lead. All of the staff we spoke with knew who this was. Staff were aware of the importance of protecting vulnerable adults and children from abuse and knew how to recognise the various signs and symptoms and how to contact the relevant agencies in and out of hours. Contact details of external organisations such as social services and the police were accessible to all staff via the practice computer system.

At the time of our inspection visit all the GPs had either level two or three safeguarding training. Those with level two were working towards level three. We were told that safeguarding training for all staff (to the specific level required for their role) was booked with an external trainer to be carried out in November 2014. Information we were shown confirmed this.

A chaperone policy was in place and posters advertising this were seen in the patient waiting room, consulting rooms and treatment rooms (a chaperone is a person who accompanies another person to protect them from inappropriate interactions). Practice nursing staff and health care assistants were formal chaperones but the practice also provided training for seven of the 14 reception staff. All the staff we spoke with understood their responsibilities when acting as chaperones. GPs and nurses documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record using recognised recording codes.

Medicines Management

We checked medicines that were stored in two fridges, controlled drugs cupboard and emergency medicines trolley and found that they were stored appropriately.

There was a policy for maintenance of the cold chain (a cold chain is the system for storing vaccines and medicines within the safe temperature range of between two and eight degrees Celsius). We saw records which confirmed checks on temperatures of the fridges were made. However, staff were unable to tell us what action they would take in the event of a potential failure in the cold chain (for example, a fridge breakdown). The practice manager told us there was a system to follow which was held on the practice computer.

Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location. These medicines were found to be available and within their use by dates.

Requires improvement

Are services safe?

Controlled drugs were held securely in a specifically designed cabinet. We found that the keys to the cupboard were kept in a secure location.

The practice had a protocol for repeat prescribing which was in line with General Medical Council guidance. This covered how the staff, who generate prescriptions, were trained, how changes to patients' repeat medicines were managed and the system for reviewing patient's repeat medicines to ensure medicine was still safe and necessary.

We were shown a prescription security policy and records confirmed that prescription serial numbers were checked. We found that blank prescriptions were stored in the GPs printers but consulting rooms were locked for security.

Cleanliness & Infection Control

All areas of the practice were visibly clean and odour free. We noted that the infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures and to comply with relevant legislation.

Arrangements were in place to ensure that the environment was well maintained. Staff told us that the practice was cleaned out of surgery hours by contract cleaners. We saw cleaning schedules and checklists that were completed to indicate that cleaning had been carried out. Regular audits were carried out to ensure that all areas were clean and hygienic.

The practice lead nurse was responsible for infection control. All staff had received induction training about infection control, specific to their role, and thereafter annual updates. Infection control audits were completed annually which met required standards.

The practice had taken steps to ensure that legionella risk assessments and checks were carried out. This ensured that water was not contaminated. The most recent risk assessment was carried out in April 2014 and followed a previous assessment in January 2014 which highlighted an issue with a shower. The second assessment confirmed that corrective measures taken had been effective.

Clinical waste was stored and disposed of appropriately with the provider keeping consignment notes on file in accordance with the clinical waste regulations.

Nursing staff wore uniforms and used personal protective equipment (PPE) relevant to their roles. For example, aprons and gloves. The lead nurse told us that staff had received hand hygiene training updates in 2013 and records and staff we spoke with confirmed this.

We were told there had been no reported incidents from sharps injuries or body fluid spillage at the practice. However, we were told about a situation when a sharp was found in the patient car park. The sharp did not come from the practice but staff treated it as an incident and followed the correct process which included discussion with staff at the next practice meeting.

Occupational health was outsourced. We were told by staff that this arrangement worked well. One member of staff told us they had received their Hepatitis B immunisation status check on December 2012.

Equipment

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, portable electrical equipment had been tested. Fire extinguishers were maintained and tested yearly.

Records confirmed that clinical equipment which included blood pressure monitors, weighing scales and the electrocardiogram machine were maintained and tested and calibrated yearly by a specialist company.

This contract also had procedures in place to deal with equipment failures and faults. Equipment such as the computer based record systems were all password protected and backed up to prevent loss of data.

Emergency equipment used to administer emergency medicines was stored on a trolley. We found three pieces of equipment (syringes) had passed their use by dates which indicated that checks on the expiry date and availability of emergency equipment was not effective. The error was corrected during our inspection visit.

Staffing & Recruitment

All the GPs and nursing staff who worked at the practice had current registrations with their professional bodies, these being the General Medical Council for GPs and Nursing and Midwifery Council for nursing staff. The practice had a recruitment policy which detailed the

checks to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

Most staff had been employed by the practice for long periods with only four being recruited in the past two years. Records confirmed these four staff had been recruited in accordance with the practice's recruitment policy.

Staff recruitment records were stored securely. Staff had evidence of having received a criminal records check such as through the Disclosure and Baring Service (DBS) where required. We saw a risk assessment for a receptionist role which resulted in the decision that a criminal record check was not required.

All the staff we spoke with told us they felt supported by the GPs and nursing team as well as by the practice management. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. The patients we spoke with told us they felt staff appeared to be appropriately skilled and knowledgeable.

The practice employed locum GPs (a locum GP is a GP who temporarily fulfils the duties of another GP). We were shown recruitment records for two locums and found that these were missing information which included employment references and employment histories.

Monitoring Safety & Responding to Risk

The practice carried out a number of risk assessments. These included fire safety, health and safety and water quality (legionella) risk assessments. All of these were carried out annually by external companies that specialised in the specific areas.

We were shown the most recent fire safety and health and safety risk assessments which contained associated action plans which had been carried out to rectify the areas requiring attention. For example, monthly emergency lighting checks.

Arrangements to deal with emergencies and major incidents

The practice had an electronic emergency call system in place on every computer to alert staff if anyone in the practice needed urgent attention. The system immediately told all staff the location of the emergency. This could be for safety or medical reasons.

All staff had received training in basic life support training within the last two years. The practice manager told us that annual training was required for the GP and nursing staff but training in 2013 had not taken place.

All of the staff we asked knew the location of the automated external defibrillator (AED) and emergency medicines.

Emergency appointments were available each day both within the practice and for home visits. Information for patients about how to access Out of Hours and urgent treatment was provided in the practice, on the practice website and through their telephone system. The patients we spoke with told us they were able to access urgent treatment if it was required.

The practice had a disaster recovery plan that included arrangements about how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. For example, a power cut or staff sickness. We saw this in action on the day of our visit when the IT appointment system failed. Staff reverted to printed appointment lists while the issue was resolved. We were told that lists were printed off in advance should the practice experience a system failure.

Mutual emergency support arrangements with three other surgeries were set up by way of a local support business continuity plan. This ensured patient care was maintained in the event of emergencies. 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

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an in depth assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff told us how they were responsible for patients' chronic disease management, for example diabetes and asthma.

Two patients told us how they regularly used the blood pressure monitor in the waiting room and took the result slip into their appointments. A GP spoke about how they carried out opportunistic blood pressure screening and how this led to more structured monitoring of a number of patients who were at risk of hypertension (high blood pressure). We reviewed seven case notes of patients who had hypertension and found these were all receiving appropriate treatment and regular reviews.

Management, monitoring and improving outcomes for people

We spoke with five GPs who each confirmed that they followed evidence based practice protocols. They also confirmed that they made use of National Institute for Health and Care Excellence (NICE) guidelines and guidance received from local commissioners. The practice undertook a small amount of minor surgical procedures for example, mole removal. Staff carried these out in line with their registration and NICE guidance.

Staff were appropriately trained and kept up to date to ensure they were proficient in carrying out procedures. Clinical audits were carried out and results were used to ensure that staff knowledge was kept up to date with current guidelines.

The practice routinely collected information about peoples care and outcomes and used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. We looked at a total of seven audits. Examples of these included, patients who took medication for osteoporosis (a condition that affects the bones, causing them to become weak and fragile and more likely to break) and referral and management of patients who had experienced a stroke. Results of the second audit showed that of the 10 patients referred to the transient ischaemic attack (mini-stroke) clinic all were referred with the correct scoring and clinical data that was recorded on the correct forms. This confirmed that patients were referred appropriately to secondary and other community care services.

Practice meetings were held where updated guidelines were shared with staff. Records confirmed this. Staff told us they openly raised and shared concerns about clinical performance and anything they felt was important to them. GPs told us they completed regular NHS health checks to identify potential health conditions which gave them the opportunity to work with the patients about how to manage these conditions proactively.

Effective staffing

There was a structured induction programme in place for new members of staff and records confirmed this was used. Areas covered included arrangements for computer access, sickness reporting, health and safety and confidentiality.

GPs undertook regular training including that provided by the clinical commissioning group. This kept GPs up to date with how to promote best practice. GPs and nursing staff met regularly to talk about individual patient's care needs. Treatment options were discussed to ensure best practice was promoted and followed.

There were arrangements in place to support learning and professional development. These included GP NHS appraisals and practice staff annual appraisals. Staff confirmed there were annual appraisal meetings which included a review of their performance, forward planning and the identification of training needs. We were told these were positive.

We looked at the results of a national GP patient survey held throughout 2013. The results showed a positive patient attitude towards the practice. For example, 92% of respondents had confidence and trust in the last nurse they saw or spoke to.

Working with colleagues and other services

There were arrangements in place for engagement with other health and social care providers.

The practice held regular multi-disciplinary team meetings which district nurses, health visitors, practice nurses and GPs attended. Information was also shared between the Out of Hours services and the practice.

Good

Are services effective?

(for example, treatment is effective)

Patient treatment information gathered by the Out of Hours service was shared with the practice the following morning. Information was reviewed by a GP first thing each morning and if necessary followed up by additional actions and any urgent matters were seen to the same day.

The district nursing team were based in the same building as the practice and had an effective communication system in place. This system was used for messages, discharge letters and test results.

Information Sharing

Patient information was stored on the practice's electronic record system which was held on practice computers that were all password protected. This information was only accessible to appropriate staff.

All staff who worked at the practice were made aware of the Caldicott provision (this sets out a number of general principles which health and social care organisations should use to protect patient/client personal information). We saw this referred to in the induction process and staff were aware of their responsibilities.

The practice had an area which contained historical paper patient records. This was located away from the public areas of the practice and accessed only by authorised staff via key coded doors.

Reception and administration staff had systems in place to add to patient records information that was received from other healthcare providers. We saw that information was transferred to patient records promptly following out of hours or hospital care. Regular clinical meetings had time set aside for information sharing with other services such as health visitors and midwives and these meetings were recorded.

Consent to care and treatment

We reviewed data from the national patient survey which showed the practice was rated below the regional patient satisfaction average for patient satisfaction about being involved in decisions about their care.

However, patients told us that they felt involved in the decisions that about their care and treatment. They said they were given adequate time to consider the options available to them and were never rushed. Another patient told us that appointment times usually ran over but understood the caring style of the GP so tolerated the wait.

We were told that patients that required end of life care and support were discussed during multi-disciplinary team meetings. Meeting minutes confirmed this.

We spoke with staff who explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. We were told that patients, who gave verbal consent to treatment, had their decision recorded on the practice computer system.

The practice told us they incorporated the use of the Mental Capacity Act (MCA) 2005 into everyday practice for people who were unable to consent. All the staff we spoke with demonstrated an understanding of the MCA and its use.

Health Promotion & Prevention

Patients were encouraged to take an interest in their health and take action to improve it. We saw a large range of health promotion information available at the practice and on its website. This information included preventative health care services available. For example, cervical smears and vaccinations for influenza (flu) and shingles. A television monitor was also in place to provide this type of information.

The practice offered health checks to patients aged between 40 and 75. During the previous 12 months 633 patients came forward out of the 1426 patient's eligible.

All of the 41 patients with a learning disability were offered an annual health check and 19 took this up.

The practice had five patients registered who had been diagnosed with Human Immunodeficiency Virus. These patients were routinely invited into the practice for flu and shingles inoculations, as appropriate.

We were told that the practice had an increasing number of patients who experienced obesity. We were told that arrangements to support them included. health walks and discount on membership for certain weight loss groups. We saw details of both of these initiatives on display in the waiting area.

The smoking status of patients aged over 16 was captured and 1108 patients were written to with information about support to stop smoking. During the previous 12 months 32 patients had been reported to have stopped smoking.

Good

Are services effective?

(for example, treatment is effective)

We saw information about other national programmes which included bowel and breast screening. For example, 75%, of those eligible for breast screening took this up.

The practice cervical smear performance was 80.1% which was better than others in the clinical commissioning group.

We were told about the process the practice followed to remind patients who did not come forward for screening. This process included three written reminders being sent to the patients registered address.

The practice offered travel vaccinations which included yellow fever and anti-malarial medicines. Information for patients who were intending to travel was included on the practice website.

The practice also offered a full vaccination program for all children who were registered. This included Measles, Mumps and Rubella (MMR), Polio, Tetanus and Human Papilloma Virus (HPV which is a sexually transmitted infection). We were told that 68 out of the 91 14-15 year old patients had received the HPV vaccination in the last 12 months.

Flu vaccinations were offered to all the patients who were eligible (those over 65, in risk groups or pregnant). We were told that over 3000 patients (81.9%) came forward for this in 2013. We saw that arrangement had been made for the 2014 flu clinics and these were advertised to start from 4 October 2014. Shingles vaccination clinics were planned for 6 October 2014 too. Patients were invited to have their vaccinations by automated telephone message system. Letters were sent to those who did not book and reminders were also provided via the practice website and patient newsletter.

We were shown a new patient registration form which included a request for information about their medical history, exercise habits, alcohol intake, smoking status and cared for or caring responsibility. These patients were also offered a health check with a practice nurse. This check included height, weight and blood pressure level together with a urine sample test.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 12 patients during our inspection who all told us they felt they were treated with dignity and respect.

Consulting and treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times patients were with GPs and nursing staff. Conversations between patients and GPs and nurses could not be heard from outside the rooms which protected patient's privacy. One treatment room contained a vaccination fridge and there was an additional curtain in place to protect the patient's dignity should another nurse enter the room.

We reviewed data from the national patient survey which showed the practice was rated above the regional patient satisfaction average by patients when asked if they were given enough time during their appointment by clinicians and their confidence and trust in the last nurse they saw.

The layout of the waiting area meant that the reception desk was in the same location but staff were aware of the need for people's privacy to be respected and were heard speaking in a quiet manner. Telephones were answered away from the desk in a separate office and appointments were made there too.

We were told that patients were offered a quiet room should they wish to speak to reception staff in private. We saw a poster on the reception desk promoting this and noted the room beside the reception desk.

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. As a result of feedback received a queuing/barrier system had been put in place to provide privacy for patients when speaking with reception staff.

We were told that the practice had an emergency 'ambulance attendance policy' which listed the actions for staff to take should a patient become unwell and require an ambulance. This involved a member of staff waiting in the car park and directing ambulance staff to the patient's location via a side entrance. We saw this in action whilst we were in reception and the patient was quietly removed from the service in a dignified way. Patients waiting for their appointments were unaware of the situation and practice functioned as normal.

Care planning and involvement in decisions about care and treatment

Patients told us that they were always given enough time during their consultation to talk about the issues that concerned them. One patient told us their consultation was detailed and a clear explanation was given about treatments and medication. Another patient told us that medicines they were prescribed were explained and risks were considered.

There was a large range of leaflets and sign-posting documents displayed for patient information to help ensure they were made aware of the options, services and other support available to them. For example, Alzheimer's and memory loss, shingles and bowel cancer.

Patient/carer support to cope emotionally with care and treatment

There was a system for assessing the support needs of carers. We saw information on display in the patient waiting room and on the practice website. Both sign-posted people to a number of support groups and organisations.

A new patient questionnaire asked if the patient was 'cared for' or 'cared for someone' and directed to a registration form for this. The form had two sections. The top section was for the carer to advise the practice of their caring/cared for status which was recorded on the patient record to alert GPs. The second section was a tear off strip for them to complete and send to a local carer's support organisation.

GPs had their own patient lists which meant they had a closer relationship with patients which appeared to work well at times of crisis. Staff told us GPs made house calls, telephoned or sent a card as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

Staff and GPs told us they took into account patients views and preferences as a natural part of consultations and would note this on their system. A patient we spoke with told us they chose to decline having a flu vaccination and this decision was respected by the GP without question.

Patients were offered choose and book (choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment at a hospital). Patients could book their own appointment through this system. Practice staff told us they would support patients who had difficulty with doing this for themselves. We were shown the process staff followed when they received patient test results. This could include making a follow up appointment for the patient or arranging further tests. Staff confirmed this process when asked.

We saw the practice 'Confidentiality Policy'. Staff we spoke with were aware of Gillick competence when asked about treating teenage patients. Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge. Staff confirmed they would make an appointment for someone under 16 if the patient had the ability to give informed consent to treatment.

Tackling inequity and promoting equality

The practice was accessible to disabled patients who required level access. We saw a disabled person's parking space close to the entrance door.

A wheelchair accessible washroom was available and a lift provided access to the first floor. There was also a baby changing facility for mothers with babies to use.

The reception desk was low which accommodated wheelchair users without them needing to move to a separate area. There was a touch screen booking-in monitor in the reception area for people to record their arrival at the practice. One patient told us they could not use the booking-in monitor because they had dyslexia. They said reception staff could be more accepting when a patient chose to book in face to face and not question their decision.

Practice staff had access to interpreting services, via language line and two hearing loops were available (one fixed and the other portable). These facilities were described on the practice website and the hearing loop symbol was advertised on the reception desk. However the symbol was not in a prominent position, it was at the back of the desk behind a leaflet stand.

Access to the service

Appointments were available in a variety of formats including pre-bookable appointments, a telephone triage system and a daily duty GP system. These ensured patients were able to access healthcare when they needed to.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. 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.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an Out-of Hours service. If patients called the practice when it was closed, the answerphone message gave the telephone number they should ring depending on their medical symptoms.

Information about the Out-of-Hours service was also provided to new patients via patient information packs and displayed on the practice website.

The practice operated extended opening hours on a Monday and every fourth Saturday, providing early morning and early evening appointments that were particularly useful to patients with work and caring commitments. The practice also held an over spill surgery at lunchtime every day for same day appointments.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

There was a complaints system in place. We saw the practice's written complaints procedure. Information about how to complain was displayed on the notice board in the waiting area, on the practice website in the patient information leaflet.

We saw a complaints log and asked to see a random selection of complaints. All of these showed that they had been investigated and resolved to a satisfactory outcome.

Two of the patients we spoke with told us they knew how to complain and also confirmed that they were confident that their feedback would be listened to and acted on.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and strategy. We were shown the practice's business plan which outlined planning objectives for future years and reviewed what resources were currently in place.

The practice's vision described how it intended to continue to provide high quality services. The document outlined how the vision would be achieved. Areas covered included; clinical performance analysis, monthly quality meetings and staff performance and development. We were shown information to confirm that the business plan was being followed.

Governance Arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business. This included roles such as safeguarding lead and infection control lead.

A GP was the Caldicott Guardian (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate Information-sharing).

Reference guides, in the form of policies and procedures, for nurses and GPs to use in the care of patients were available on the practice electronic library. This was available to staff on all the computers in the practice.

We selected six practice policies and procedures to review. These included safeguarding children, infection control, confidentiality, recruitment, medicines management and complaints. We were told that all practice policies were reviewed every year. All of the six we looked at had been reviewed in July 2014.

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 national standards. We saw that QOF data was regularly discussed at QOF specific monthly team meetings and action plans were produced to maintain or improve outcomes.

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

We saw records to support the identification and management of risks which included health and safety, legionella and fire safety. We were shown risk assessments for all three which had been carried out in 2014. We also saw assessments for the previous year.

Leadership, openness and transparency

Staff told us they found the leadership at the practice was visible and accessible. They told us that there was an open culture which encouraged the sharing of information and learning.

All the staff we spoke with told us they felt valued and listened to. One told us that communication was good between departments and there was a positive culture but on occasion the GPs didn't always tell key staff they had left the building which caused confusion.

Team meetings were held every month where staff were given the opportunity to raise issues. Records of minutes confirmed this. Staff told us they attended 'away days' to improve their knowledge. Examples given were 'conflict resolution' and 'telephone skills'.

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, feedback from patients was used to help the practice to learn and improve. The PPG told us that they felt involved in the service and the practice senior management engaged with the PPG and acted on their feedback.

The PPG met at least every eight weeks. The practice also had a group of patients known as a virtual Patient Reference Group (PRG). The PRG was contacted from time to time via email to complete patient surveys.

Patient's views were sought on a number of topics which included patient's ability to get an appointment with their own GP (both scheduled and urgent). Results of the survey identified that whilst 60% of the patients responded, they did so positively about the speed of securing an appointment, 29% responded negatively. We were told that the practice acted on this information which resulted in the recruitment of an additional GP.

Are services well-led?

Good

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

Management lead through learning and improvement

We noted that there was an effective system of appraisal in place which the staff found to be relevant and meaningful. Staff told us they had an opportunity to talk about their training needs during their annual appraisal. There were arrangements in place to manage staff performance.

Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

The practice took account of complaints to improve the service and significant events were discussed and learnt from through regular quality meetings.

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 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered person must – Ensure equipment is properly maintained and suitable for the purposes of the regulated activity. Equipment used to administer emergency medicines was not monitored to ensure it was available and fit for purpose (within use by date).

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 The registered person must – (1) (a) Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person - is of good character Two locum GPs started to work at the service before relevant recruitment checks were carried out.