

Rectory Meadow Surgery

Quality Report

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

Ratings

Overall rating for this service

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rectory Meadow Surgery on 29 April. Overall the practice is rated as good. Specifically, we found the practice to be good for providing effective, caring, responsive services and for being well led. It was also good for providing services for the all population groups. It required improvement in providing safe services.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Significant events and complaints were fully investigated and led to changes in protocol and practice which were communicated among staff.
- Staff had access to regular meetings which enabled them to be involved the running of the practice.

- Most potential risks to patients were assessed and well managed including, premises maintenance, equipment checks and emergency procedures.
- Most but not all staff checks required were undertaken.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Care was provided by named GPs to patients in the community.
- Staff training was identified, monitored and undertaken to ensure staff could fulfil their roles safely and effectively.
- Patient feedback showed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients provided positive feedback about the appointment system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider must make improvements.

- Undertake Disclosure and Barring Service (DBS) checks on all nursing staff and ensure GPs' registration with their professional body is checked to ensure these are up to date and identify any concerns or conditions.

Additionally the provider should :

- Ensure staff have accurate information and training regarding action to take in the event of needle stick injuries

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Not all nursing staff members had a Disclosure and Barring Service (DBS) criminal background check. Staff did not have access to accurate and up to date guidance on the procedure in the event of needle stick injuries. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice was mostly clean and hygienic. Hygiene and infection control checks were in place, but not all guidance was followed in relation to the storage of clinical waste.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Our findings during our inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG) and nationally. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams internally and externally to deliver positive health outcomes for patients.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care. The practice

Good



Summary of findings

supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated good for providing responsive services. The practice reviewed the needs of its population and engaged with NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had initiated positive service improvements for its patients and acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys. Patients told us it was easy to get an appointment and a named GP, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to make a complaint was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority whilst ensuring patients and their carers have a positive experience. All staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. High standards were promoted by all practice staff and teams worked together across all roles. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients which is acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended meetings and events.

Good



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

The practice is rated as good for the care of older people. The practice had the highest number of over 75s in the locality at 15%. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. End of life care was well managed and this included high numbers of patients with a preference to die at home having this wish respected (93% of patients died at home in 2014/15). End of life care included external professionals in planning and implementation. The practice was responsive to the needs of older people; they offered home visits, regular reviews of care for patients in a local care home and rapid access appointments for those with enhanced needs. Patients in care homes had an allocated GP. The premises were easily accessible for patients with limited mobility. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. The practice had improved its diagnosis rate for dementia significantly within the last year.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. Chronic disease management was well managed within the practice, and this was reflected in national data and tools used to plan patients treatment and care. Plans for patients at risk of unplanned admissions to hospital were written to reduce the risk of this occurrence. Longer appointments and home visits were available when needed. There were lead GPs and nurses for managing specific conditions such as diabetes and respiratory diseases. This enabled staff to provide expertise in caring for these conditions. Nurses received training to provide reviews of patients health needs. The practice endeavoured to ensure patients saw only their named GP to maximise the continuity in their care.

Good



Families, children and young people

The practice is rated as good for the care of families children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, and systems to ensure staff were aware when seeing children who were at risk of harm or abuse. Immunisation rates were close to

Good



Summary of findings

average for most standard childhood immunisations. The premises were easily accessible for patients attending with prams and buggies. Sexual health advice and services were available to patients. Pre and post-natal clinics were provided.

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). Online appointment booking was available. There were extended hours appointments on Monday nights. Feedback regarding the appointment system was very positive from patients. Travel clinics were available. The practice provided a full range of health promotion and screening that reflected the needs of this age group. New patient health checks were offered.

People whose circumstances may make them vulnerable

Good



The practice is rated good for the care of patients whose circumstances make them vulnerable. The practice had carried out checks for patients with a learning disability and offered these patients longer appointment slots. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked with patients in local supported living accommodation and provided them with named GPs, health advice and care planning. Staff confirmed that any patients who did not have an address to provide to the practice, would still be seen by an appropriate clinician.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of those experiencing poor mental health. Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and early screening for the disease. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling was available to patients on-site.

Summary of findings

What people who use the service say

During our visit we spoke with twelve patients, including a member of the practice Patient Participation Group. We reviewed 35 completed CQC comment cards. Patients were very complimentary about the GPs, the reception staff and the care and treatment they received. They said they could get an appointment when they wanted one and the doctors took their time during consultations carefully explaining whilst listening to the patients.

These comments were consistent with the results of the most recent (January 2015) National Patient Survey which also indicated high levels of satisfaction with the practice and staff. Of the 123 patients who responded,

95% say the last appointment they got was convenient and 83% described their experience of making an appointment as good. These comments were also consistent with the National Patient Survey where 94% of those who responded said that the last GP they saw or spoke to was good at listening to them.

The Friends and Family Test (FFT) on the practice website similarly confirmed patients' satisfaction with the service they received. Results of the most recent FFT (March 2015) indicated 90% of respondents were extremely likely to recommend Rectory Meadow Surgery to Friends and Family if they needed similar treatment.

Areas for improvement

Action the service **MUST** take to improve

- Undertake DBS checks on all nursing staff and ensure GPs' registration with their professional body is checked periodically.

Action the service **SHOULD** take to improve

- Ensure staff have accurate information and training regarding action to take in the event of needle stick injuries

Rectory Meadow Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The team included a GP specialist adviser, a director of a GP federation and three CQC inspectors including a lead inspector.

Background to Rectory Meadow Surgery

Rectory Meadow Surgery is located in Amersham. The practice premises are purpose built. Patients are registered from the local area. The practice population has the highest proportion of patients aged over 75 years in the clinical commissioning group (CCG). There is minimal deprivation according to national data. The prevalence of patients with a long term health problem is 51% compared to the national average of 54%. The practice had a higher than national average proportion of patients residing in local care and nursing homes at 0.7% of the population. It also provided care to patients in supported living accommodation. Approximately 9,000 patients are registered with the practice.

Care and treatment is delivered by five GP partners (including a mix of males and females), four practice nurses, one health care assistant and a phlebotomist.

The practice is a member Chiltern CCG.

This is a training practice. The practice had a General Medical Services (GMS) contract. GMS contracts are directly negotiated between the General Medical Council and the practice.

We visited the Rectory Meadow Surgery as part of this inspection. The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider and NHS 111.

Rectory Meadow Surgery, School Lane, Amersham, Buckinghamshire, HP7 0HG.

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), local Healthwatch, NHS England and Public Health England. We visited Rectory Meadow Surgery on 29

Detailed findings

April 2015. During the inspection we spoke with GPs, nurses, the practice manager, deputy manager and reception staff. We obtained patient feedback from speaking with patients, comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

- Is it safe?

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

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

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

Are services safe?

Our findings

Safe Track Record

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards and patient interviews on the day of inspection reflected this.

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 as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, confident in raising concerns and how to report incidents and near misses. For example, one member of staff told us how they had responded when a patient started to become challenging to staff whilst sat in the practice waiting area and this was identified and recorded as a significant event. The practice told us whilst reviewing the event they had identified several different actions which the practice could take to improve. The member of staff described the learning from this event and how procedures in handling this type of situation had been changed. They confirmed that the practice provided information and practical advice on communication skills and personal safety to all members of staff when dealing with challenging behaviour.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Staff we spoke with were able to give examples of recent safety alerts relevant to the care they were responsible for.

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 year and these were made available to us. Monthly significant event meetings were held by GPs and staff were invited to attend these to discuss and learn from significant events and complaints. Weekly clinical meetings

were held each Friday and this was an opportunity to further discuss, review and action any learning. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

Staff including receptionists, medical secretaries and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. We saw incident forms were available on the practice intranet including three example templates to act as a guide for anyone reporting an incident for the first time. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We looked at documentation from four significant events and saw records were completed in a comprehensive and timely manner. Evidence of actions taken as a result was shown to us. For example, following a patient's feedback when they reported receiving contradicting advice following treatment, systems and a change in practice process had been implemented to reduce the risk of this happening again.

National patient safety alerts such as alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated by the practice manager to all staff.

Reliable safety systems and processes including Safeguarding

The practice had systems to manage and review risks to children, vulnerable young people and vulnerable adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. 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 appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had received level three safeguarding training related to this role. All GPs and most of the nursing team at the practice had also completed level three

Are services safe?

safeguarding training, whilst all practice staff had completed level one training. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as a chaperone other members of the practice had also undertaken training. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to observe the examination and what to do if they had any concerns regarding the examination.

There was a system and computer coding to highlight vulnerable patients on the practice's 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 or patients with learning difficulties.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals and results from tests and x-rays. All practice staff had completed information governance training including modules on confidentiality and password management. We saw training certificates and observed staff access, manage and store patient records in a safe and confidential manner.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Practice staff were aware of the action to take if the fridge temperature range was not maintained.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that medicines used in the practice were in date. There was also a system in place for checking the medicines in GPs home visit bags.

We saw that there were systems in place to review prescribing in nursing homes, repeat prescribing and monitoring of prescribing for specific conditions such as cardiovascular disease.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy with only a small amount of high level dust in one of the consultation rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

We saw there were cleaning schedules in place and cleaning records were kept. However, despite an infection control audit identifying high level dust, we found some consultation rooms had dust on top of cupboards. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead nurse for infection control and an infection control policy for staff to refer to. We saw evidence that infection control audits had been carried out, the most recent was in December 2014. Any improvements identified for action were completed on time. Issues identified were discussed at staff meetings and a member of the nursing team described to us recent changes and renovation of the reception area that had taken place to address infection control issues that had been identified.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

There was a policy for needle stick injuries and staff knew what to do if this occurred. However the practice policy for needle stick injuries did not reflect the required immediate action following such an injury. We saw that staff had received the relevant immunisations.

Are services safe?

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that the disposal was arranged through a suitable company. However, we observed that the external clinical waste bins were locked but not stored in a secure area..

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A legionella risk assessment had been completed in June 2014. We saw records that confirmed the practice had arranged for an annual service whilst carrying out regular checks in line with the policy to reduce the risk of infection to staff and patients.

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as an automated external defibrillator (an electronic device that applies an electric shock to restore the rhythm of the heart) was available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date and further schedules of testing were in place. The practice used an external company to complete equipment calibration; we saw evidence of calibration of relevant equipment such as weighing scales, spirometers and blood pressure measuring devices.

Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements.

Staffing & Recruitment

There was little turnover of staff and sickness absence was low. Staff told us this promoted consistency and both the practice staff and patients commented that Rectory Meadow Surgery have a committed team. Staff also commented that they felt well supported and involved in the running of the practice.

Patients were cared for by suitably qualified and trained staff.

We saw the practice had a recruitment policy, the policy sets out the standards it followed when recruiting clinical and non-clinical staff, this policy had been recently been reviewed. The policy stated that suitable candidates for a position would be interviewed and notes of the interview made. For successful candidates identity checks would be made, two references sought and a disclosure and barring check (DBS) carried out where appropriate.

We looked at staff records and found that most appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references and qualification. Newly appointed members of staff had a Disclosure and Barring Service (DBS) checks, however not all nurses had a DBS check. Nurses work alone with patients and therefore should have criminal record checks undertaken. The practice had not checked all GPs current registration with the General Medical Council. Nurses registration with the Nursing and Midwifery Council was checked.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was 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.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

One of the GP partners explained to us that there was a protocol for GP annual leave and if they knew that there was a forthcoming shortfall in GP cover they would arrange for extra sessions to be worked by existing GPs as far as possible. There were arrangements with locum GPs who had provided cover when necessary to the practice.

Following previous patients' comments and feedback, the practice had consulted with all reception team and revised the shift patterns to increase the numbers of receptionists at busy times. Comments from patients who completed

Are services safe?

CQC comment cards reflected that this change in reception shift patterns had improved accessibility to the practice. The practice used medical secretaries who were also trained to assist the reception team during busy times.

The medical secretaries explained they had responsibility for an individual GP's communication with patients and regarding patients care at external services. They all had a deputy to ensure their work and individual GP patient lists were covered when they were absent.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and had completed Control of Substances Hazardous to Health (COSHH) risk assessments.

Staffing establishments were reviewed to keep patients safe and meet their needs. Where staffing issues had been identified, we saw that action plans were in place outlining how risks would be managed and work re-allocated. We saw that risks were assessed, rated and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice used a nationally recognised patient safety framework to enable them to identify patients at risk.

There were emergency processes in place for identifying acutely ill patients, they were provided with on the day appointments when needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support (Adult and Paediatric), Anaphylaxis and Automated External Defibrillator.

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check emergency medicines were within their expiry date and suitable for use and we saw that they were.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of domestic services, adverse weather (snow), staff shortages and IT failure. 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 that included actions required maintaining fire safety. We saw records that showed staff were up to date with fire training but no fire drills had been undertaken for two years.

The practice had a Health and Safety policy that included fire prevention and safety and this was covered during new staff inductions. Staff we spoke with clearly described their roles and responsibilities in keeping patients safe in the event of a fire.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence that new guidelines were disseminated and that the practice's performance was reviewed where necessary. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs had their own patient lists and were responsible for managing their own patients care and treatment needs. Staff told us that this worked well. Patients told us they valued being able to see their own GP. There was a strong ethos of providing personalised care within the practice. This was reflected in the care provided to patients in a local supported living complex. The GPs told us they had been able to work with the same patients and provided robust health checks, including advice on lifestyle (particularly smoking cessation advice).

The GPs and nurses led in clinical areas and had training relevant to these roles such as diabetes and respiratory diseases. Nurses received training to enable them to lead in specific long term conditions. This enabled the practice to effectively manage specific long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of specific medical conditions. We saw clinical meeting minutes which confirmed that this happened.

We completed a review of templates used to review patients' conditions and determine whether their treatment was appropriate and effective. The templates indicated that patients with long term conditions were receiving appropriate reviews and treatments. The practice employed a specialist diabetic nurse who was instrumental in planning and managing the care of patients with

diabetes. This involved improving the coding of patients on the computerised patient record system which enabled the practice to screen for conditions which diabetic patients may have been at risk of.

Care plans for patients at risk of unplanned admissions were created as part of an enhanced service (a funded service beyond the contractual obligations of the practice). National data showed that the practice was in line with referral rates to secondary and community care services. There were 412 long term conditions emergency bed days in 2012/13 compared to national average of 458. A&E attendances in 2014/15 were 167 per 1000 which was among the lowest in the CCG. Elective inpatient admissions were significantly lower than the national average of 24% and the CCG average of 16%, with the practice at 12%. The practice communicated regularly with consultants to avoid referrals wherever possible.

The practice had a low recorded diagnosis rate for dementia at 0.3% despite the older population at the practice (this figure is adjusted according to the number of patients in care and nursing homes). As a result of this low diagnosis rate the practice had reviewed its recording of assessments of patients at risk of dementia. The practice had improved its recording of screening rates as a result from 22 patients diagnosed in early 2014 to 44 by the end of 2014.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. There were examples where patients' circumstances had been considered to ensure they were able to attend the practice when they needed, such as patients with no fixed address.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Each GP had a secretary responsible for all communication related to that GP's list of patients. Staff told us this provided strong continuity in care and improved communication for patients.

Are services effective?

(for example, treatment is effective)

The practice showed us several clinical audits which had been undertaken in recent years. Audits were undertaken in response to medicines management information, trainee GP's learning needs, safety alerts or as a result of information from the quality and outcomes framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw an audit on atrial-fibrillation which indicated that the repetition of the audit from 2011 to 2014 had improved the uptake of patients on the medicine considered best practice for treatment of the condition. We saw a number of audits were repeated and completed to ensure that their findings led to improvement in practice. Significant events also led to changes in patient care. A change to the process of caring for patients after discharge from hospitals was made to ensure patients received the care they needed. This was in response to a significant event where a patient had not been discharged home but the practice tried contacting them to provide follow up care.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed well on QOF across the majority of clinical outcomes and public health indicators achieving nearly 100% overall in 2015.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice had identified that it was a higher prescriber than the national average for some antibiotics. The practice had reviewed the prescribing of these medicines and had significantly reduced their usage.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding. There was a training log which identified what training was

required by staff and when this would need to be updated. We noted a good skill mix among the GPs and nurses. All the GPs attended local meetings to discuss clinical topics with other GPs and share learning. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice had induction plans for different staff roles which included various aspects of training specific to the practice's policies and protocols. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was responsive when staff identified training needs they were supported and funded for relevant courses. Nurses attended courses for the care of specific conditions. There were systems in place to disseminate relevant learning through team meetings. These regularly attended by all staff. We saw minutes of the various team meetings. Nurses attended nurse forums externally to help promote good practice.

The practice kept a log of staff training for non-clinical areas such as health and safety, infection control and information governance. This indicated staff had received recent training in all the areas identified as requiring periodic training updates. Staff confirmed they undertook these training topics.

Trainee GPs were monitored and supervised by their GP mentor. The practice used video footage and medical notes to help trainees develop their skills and ensure patients were receiving appropriate care and support.

Working with colleagues and other services

The practice worked with other service providers to provide patients' care including those with complex care needs. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Test results were dealt with in a timely way.

The practice worked with the district nursing team, health visitors and midwives. GPs told us there was a

Are services effective?

(for example, treatment is effective)

multi-disciplinary team meeting held regularly. This included the district nurses, health visitors and palliative care nurses. The minutes of the meetings showed us that care of patients that required the input from various staff was discussed to ensure co-ordinated care was given. There was evidence of working with other healthcare professionals and voluntary bodies.

Information sharing

The practice used electronic systems to communicate with other providers and internally. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

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

Consent to care and treatment

We found that GPs and nurses were aware of the Mental Capacity Act 2005. All the staff we spoke with understood the key parts of the legislation. Staff gave examples of when they would need to refer the principles of the Act. We saw evidence of staff gaining consent from patients for specific procedures, such as minor surgery.

Staff were aware of the Gillick Competencies (this refers to the rights of children to make decisions about their treatment between the ages of 13-16). Staff told us they were aware of their responsibility to gain consent from patients and we saw evidence in patient records that consent was discussed.

Health promotion and prevention

GPs told us of a range of health promotion services they were able to access for their patients. For example, counselling was available in the practice. The website contained health advice and information for its patients including child health, pre-natal care advice, men's and

women's health, child health and sexual health. A range of health promotion information was available in both the main waiting area and in clinical rooms. Health checks were offered to new patients.

The practice kept a register of all patients with a learning disability and they were offered an annual health check. The practice had also identified the smoking status of 82% of patients over the age of 16 (below the national average) in 2013/14 and actively offered smoking cessation advice to 91% of these patients in 2014/15. The practice had identified 4% of these patients had quit smoking as a result.

The practice's performance for cervical smear uptake was 81% in recent years, which matched the national average and target of 80%. 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 child immunisations was above average for all vaccines where data was available under 12 months (100%) of age and close to or above average for children over 12 months to the age of 5 (96%). Whooping cough vaccinations were offered to pregnant women. Flu vaccinations were offered and the uptake among those over 65 was higher than the national average at 79% in 2014/15 and for patients eligible for flu vaccinations due to risks associated with specific conditions such as coronary heart disease or diabetes the uptake was high at 89% in 2015.

Other screening services included bowel cancer screening: seventy one per cent of patients eligible to be screened for bowel cancer had been screened in the last year. The practice also provided chlamydia screening to patients. The prevalence of chlamydia is much higher among those under 25 years old and the proportion of patients from 16-25 was approximately 10% at this practice, much lower than the national average. However, 92 patients were screened for the infection in the last 12 months despite the low number of patients under 25.

A full range of contraception services including implant fitting and intrauterine contraceptive devices were available at the surgery. Patients had access to 24 hour blood pressure monitoring which increased the accuracy when assessing and diagnosing hypertension.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The most recent national GP survey data (January 2015) for Rectory Meadow Surgery based on 123 completed surveys (48% response), showed patients were satisfied with the services provided. For example, 89% of respondents rated their overall experience of the surgery as good and 91% would recommend the surgery. The practice achievement across all areas was above or in line with the local average. They performed particularly well for patients being able to see or speak to their preferred GP: 92% compared to the local average of 64%. The proportion of patients who stated staff were good at treating them with care and concern was 90% for doctors and 88% for nurses. Patients were also satisfied with the listening skills of both GPs (94%) and nurses (86%).

The practice welcomed feedback from the public, via a suggestion box in the reception area, NHS choices website and the NHS Friends and Family test (FFT). The FFT results for the last three months were very positive with 97% patients extremely likely or likely to recommend the practice in January and February 2015 and 98% in March 2015.

We spoke with 12 patients during the inspection. They were a mix of patients, male and female, parents with young children and older patients. All except two patients had been with the practice more than 10 years and all had other members of the family who also attended. We also spoke with representatives of the patient participation group (PPG). All the patients we spoke with were extremely positive about the care and treatment they received. They told us all staff treated them with respect and kindness.

We received 35 comments cards from patients. All the comments regarding the care received from the practice were positive and some included specific examples of compassionate care and many referred to the consideration of GPs, nurses and reception staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception desk was located away from the waiting area. A space was available adjacent to the reception desk for patients to use the BP machine in privacy and also for private conversations if needed.

All staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, during the inspection we witnessed numerous caring and compassionate interactions between staff and patients which demonstrated how staff treated patients with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GPs and nurses were good at involving them in decisions about their care and 87% said GPs were good at explaining tests and treatment, compared to 90% for nurses. Both these results were above or very close to the CCG average.

All the patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patients preferred methods of communication was recorded and the practice sought the patients consent before messages were left on answerphones.

Are services caring?

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed.

Patient/carers support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were very positive about the emotional support provided by the practice.

A list of palliative and vulnerable patients was updated daily. Staff were aware of patients or recently bereaved

families so they could manage calls sensitively and refer to the GP if needed. GPs told us that 93% of their patients receiving end of life care died at home, if this was their preference.

A number of notices in the waiting areas, the information screen and practice website informed patients on how to access a number of support groups and organisations. For example, bereavement support and managing anxiety and stress. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them locally.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood by staff within the practice and systems were in place to address identified needs in the way services were delivered. This included recognition of local supported living accommodation nearby, the older population of Amersham and the number of patients cared for in nursing and care homes. Homeless patients who needed to see a GP at the practice would be registered at the practice address. Care homes were allocated to individual GPs for continuity of care. Staff told us this meant the continuity of care for these patients' was better than having different GPs visiting the homes. GPs were aware that consistency of care was a concern for patients living in local supported living accommodation with mental health problems or learning disabilities. They told us they believed this was due to having many different GPs in the past when registered at various practices. The GPs told us they valued working one to one with these patients to improve care planning, the advice they could give and gain a better understanding of the patients' needs. They said the patients they spoke with valued this.

Travel health advice and vaccinations were offered onsite and 305 patients were given travel advice in the last year. A phlebotomy service and dietician were available onsite. These services were particularly useful to patients who worked and would prefer to access these services locally rather than travelling to clinics in nearby towns. Text messaging was available to remind patients about their appointments. There was a blood pressure machine in a private area in the reception which was convenient for patients to use.

Changes were made to the service where concerns were identified. Following an incident where a patient with autism presented behaviour which challenged staff, training was provided by the National Autistic Society to help staff deal with such a situation in the future. The doors in the practice were being replaced to sound proof ones and other changes had been made to reduce the likelihood of conversations being overheard during consultations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to

translation services including a phone translation service. This made it easier for patients with urgent concerns who did not speak English to access care and treatment at the practice. Staff told us that there were very few non-English speaking patients registered with the practice.

The premises and services had been adapted to meet the needs of patient with disabilities or limited mobility. Level access at the front of the building made it suitable for wheelchairs and mobility scooters. All consultation and treatment rooms used by the practice staff were on the ground floor. Vulnerable patients were flagged on the patient record system. There was a hearing aid loop. The premises had wide corridors and doorways were wide enough for large wheelchairs. Height adjustable couches, which made it easier for patients who had limited mobility, were available in consultation and treatment rooms.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:30am to 6pm. Two thirds of appointments were kept free every day for booking on the day and one third were available for advanced booking by up to six weeks ahead. Patients could book appointments in advance or for the same day via online booking, in person or on the phone. If all same day appointments were taken there was a telephone triage system for emergency appointment requests. Extended hours appointments were available on Monday evenings.

In the national GP survey 83% of patients reported good overall experience of making an appointment. Ninety two per cent were able to get an appointment to see or speak to someone the last time they tried and 91% were satisfied with phone access compared with 74% in the local CCG. Feedback on access to a preferred or named GP was much better than the national average with 92% of patients saying they could usually see their choice of GP, compared to 64% nationally.

Demand and capacity audits were undertaken in 2011 and 2014 to determine the effectiveness of the appointment system. The system had been subject to changes to

Are services responsive to people's needs?

(for example, to feedback?)

improve access for patients as a result of this. Feedback from patients and comment cards left by patients suggested that the majority of patients were satisfied or very satisfied with the appointment system.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. The number of patients using the local out-of-hours service registered at this practice was among the lowest in the local CCG.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who required them, by a named GP and to those patients who needed one.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We looked at several complaints and found they were responded to appropriately. The process for investigating them had been followed. We saw that information was available to help patients understand the complaints in the form of information in the practice and on the website.

Are services well-led?

(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 to deliver high quality care and promote good outcomes for patients. All the staff we spoke with spoke about the delivery of patient services as the core principle in their work. The practice leadership team was aware of potential changes which may affect the practice in the future. There was a relatively stable patient population. The practice valued its low turnover of staff. GPs told us they liked working at the practice, the culture and its commitment to patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at policies and found they were reviewed regularly and up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. The leads in these areas had their roles clearly defined and were proactive in delivering changes where necessary. For example, the diabetic lead nurse had reviewed the process for diabetic health checks and staff were aware that this was their role and what the changes meant to them. Staff were clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) and audits to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data and audits were discussed at staff meetings. Audits led to changes in practice and improvements where they were identified.

The practice had arrangements for identifying, recording and managing risks. There was a plan to undertake more frequent fire drills and protocols were in place for fire safety. Health and safety risk assessments were undertaken as well as resulting actions where necessary.

Leadership, openness and transparency

We saw minutes from regular partnership meetings, monthly clinical, staff and multi-disciplinary meetings. Staff were able to attend meetings regularly. Nurses met with

the partners when they needed to and could discuss any concerns and recommendations they had. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or to their line manager or a GP if required. Staff we spoke with knew who to report concerns to about specific issues such as safeguarding and also had line managers to ensure they knew where they could access support if needed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the friends and family test (FFT) and used external feedback from the national GP survey.

The practice had a virtual and physical patient participation group (PPG). The virtual group was communicated with via e-mail. The physical PPG met regularly and was fully involved in decisions about the practice. GPs told us the group was still in need of development. There was a clear and detailed action plan developed by the PPG and practice to improve the representativeness of the PPG. We spoke to a PPG member who was complimentary about the involvement of the group in the running of the practice.

The practice had gathered feedback from staff through meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at several staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they could attend external training events. The practice was a training practice and we spoke with doctors in training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. These actions were followed up at the subsequent

Are services well-led?

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

meetings to ensure changes had been made. The practice had identified a high number of significant events. Complaints were investigated to identify any learning or changes which may have been required by the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Not all information specified under Schedule 3 was available. This included a lack of criminal background checks and records related to the registration of staff with their relevant professional bodies. Regulation 19 (3)(a)(b)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	