The Andover Health Centre Medical Practice

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?	Good
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 a comprehensive inspection of The Andover Health Centre Medical Practice on 27 November 2014. The practice is situated at Charlton Road, Andover, Hampshire. SP10 3LD. The practice is a training practice for GPs.

The practice is rated as good overall.

Our key findings were as follows:

- Patients were able to access appointments via telephone, online or in person. Extended pre bookable appointments were offered each day from 7.30am with GPs and nurses.
- Patients told us they were treated with respect and treatment and care options were explained to them.
- There were suitable systems in place to protect patients from harm and staff were aware of the need to report any safeguarding concerns they had.
- Arrangements were in place to minimise the risk of cross infection. The practice had a contract to provide palliative care to a local hospice; GPs carried out ward rounds on week days.
- Alerts were placed on patient records that had type one diabetes to check for coeliac disease. (Coeliac disease is a lifelong autoimmune disease caused by intolerance to gluten).
- The practice were not always made aware of a woman's pregnancy as communication was not effective between the practice and the midwifery service. GPs said that midwives had agreed to send information on a weekly basis to the practice but this had not occurred and this issue was ongoing.
- Palliative care meetings were held every two months and attended by Macmillan nurses and on occasion a consultant in palliative care.

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

The provider should:

- Provide safeguarding adults training for all staff relevant to their roles.
- Include information when responding to complaints about access to advocacy services, the Parliamentary Ombudsman or the role of NHS England in complaints handling.

Summary of findings

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. There were enough staff to keep patients safe.

Staff were aware of safeguarding vulnerable adults and children, but had not received formal training on safeguarding adults.

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. Emergency medicines and associated equipment was available and safe to use.

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. 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 is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect and maintained confidentiality.

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 and was proactive in seeking the views of patients and responded to their suggestions to improve the service.

Summary of findings

Are services well-led?

The practice was rated as good for well-led. The practice had a clear vision and strategy, 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.

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

Good

The practice is rated as good for the care of older people. 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 and had a range of enhanced services, for example, in end of life care and hospital admission avoidance. It was responsive to the needs of older people, and offered home visits and longer appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations and a process was in place to follow up non-attenders. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Staff we spoke with were aware of the needs of treating young patients and the consent required. Alerts were place on the records of children who may be at risk of harm.

Maternity services were midwife led and antenatal appointments were not routinely carried out at the practice due to the midwifery service being in the same grounds as the practice premises. Lack of clear communication from the maternity services meant that the GPs did not always know when their patients were pregnant.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients who were vulnerable for example, those with a learning disability. It had carried out annual health checks for people with a learning disability and longer appointments. Arrangements were in place to support patients with a learning disability to make informed decisions and aids used included pictures.

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.

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

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). The practice had a register of all patients with dementia and offered an annual review. Detailed care plans were drawn up with the involvement of the patient whenever possible. The practice did not have a significant number of patients experiencing mental health problems, but were able to offer rapid access or longer appointments if needed.

Summary of findings

What people who use the service say

During our inspection we spoke with eight patients and reviewed 40 comments cards which had been completed by patients in the two weeks preceding our visit. All patients we spoke with were complimentary about the service provided. They told us they were able to see a GP or nurse if their condition was urgent. All staff who worked at the practice treated them with respect and their privacy was maintained. GPs and nurse gave patients sufficient information in order that they could make an informed decision about care and treatment. The comment card reflected what patients told us during our inspection.

Areas for improvement

Action the service SHOULD take to improve

- Provide safeguarding adults training for all staff relevant to their roles.
- Include information when responding to complaints about access to advocacy services, the Parliamentary Ombudsman or the role of NHS England in complaints handling.

The Andover Health Centre Medical Practice

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 and a practice manager.

Background to The Andover Health Centre Medical Practice

The Andover Health Centre Medical Practice is situated at Charlton Road, Andover, Hampshire, SP10 3LD. The practice has approximately 14,000 patients registered with it. There are 10 GP partners who provide a total of 6.66 whole time equivalent hours (WTE), two of these partners are GP trainers and there are seven female and three male GPs. The practice has five practice nurses who provide 3.43 WTE hours and two health care assistants who provide 1.28 WTE hours. The GPs and nurses are supported by a practice manager and assistant practice manager who work full time and a team of reception and administration staff who provide a total of 10.93 WTE hours.

The practice is a training practice and usually has one GP in training attached to the practice. The practice has a General Medical Services contract.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Out of hours service are provided by another provider, patients can either telephone a designated out of hours number or the 111 service.

The practice population was marginally above the national average for the age group 44-54 years old. There was approximately a 50% ratio of male to female patients. A total of 86% of patients' surveys would recommend the practice.

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, 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 that we hold about the practice and asked other organisations to

Detailed findings

share what they knew. We carried out an announced visit on 27 November 2014. During our visit we spoke with a range of staff which included the practice manager, GPs, nurses, health care assistants and reception staff and spoke with patients who used the service. We reviewed 40 comment cards where patients and members of the public shared their views and experiences of the service.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The practice computer system had specific forms for staff to record significant incidents and near misses. These were also discussed by GP partners informally and at monthly practice meetings, examples included prescribing errors and breaches of confidentiality. The practice also held a significant event meeting every six months to review all issues and to ensure appropriate action had been taken and the risk of reoccurrence was minimised. Urgent significant events were discussed at the Monday Partners meeting. We reviewed safety records, incident reports and minutes of meetings where events were discussed which demonstrated appropriate action had been taken. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held six monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. One nurse gave us an example of a care that had not been recorded, which had resulted in a positive outcome for the patient and demonstrated that the practice procedures had been followed.

National patient safety alerts were shared by the practice manager via email to practice staff. Staff gave us examples of recent alerts that were relevant to the care they were responsible for. The GP responsible for managing medicine alerts received gave an example of when a medicine was recalled and said that they ensured that the appropriate staff and actions were taken. This was achieved with the assistance of the administration team who ran searches on the practice's data base to identify patients who needed to be contacted.

Reliable safety systems and processes including safeguarding

One of the GPs was the nominated lead for safeguarding for adults and children at the practice. We found that all GPs who worked in the practice had received level three training for safeguarding children. Nurses who worked in the practice had received level two safeguarding for children. Staff we spoke with confirmed this and were able to give examples of potential safeguarding concerns and how they would report this information to the relevant person, such as the lead GP. Contact details of relevant agencies, such as the local authority were readily available on lists in consulting rooms.

However, staff had not received formal training on safeguarding adults relevant to their roles, but were able to give examples of behaviours which could indicate whether a patient was subject to abuse and who they should report their concerns to. We were told about an adult safeguarding referral that had been made about the care of one patient. This occurred when other health professionals had informed a GP of their concerns about a particular patient. We also found that there were indictors on patient records if there was a risk of domestic violence. Policies relevant to safeguarding were available in hard copy for staff to access, along with those held on the shared computer drive.

We were shown a list of codes which were added to child patient records which indicated whether there was a risk of abuse, but this was not put into place for adult patients who might be vulnerable. The practice said that health visitors who were based in the practice held a list of children who were subject to safeguarding and their needs were regularly discussed with the practice. Vulnerable patients of all ages were also discussed at monthly practice meetings that district nurses and social workers attended.

Staff were aware of services for young adult patients and said there was a young vulnerable adult drop in centre nearby they could tell young patients about, and the local Child and Adolescent Mental health unit on the ground floor of the building.

Good

Are services safe?

There was a chaperone policy , which was visible on the waiting room screen. All nursing staff, including health care assistants, had been trained to be a chaperone. 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.

Medicines management

The practice had a nominated person responsible for medicines and prescriptions management at the practice. We checked the medicines stored on 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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential power failure. We saw that vaccines expiry dates were checked on a weekly basis and refrigerator temperatures were checked three times a day when the practice was open. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings and audits that were taken in response to a review of prescribing data. For example, an audit cycle had been completed in November 2014 on the use of anti-platelet therapy (blood thinning medicines) following a patient experiencing a heart attack. This had resulted in medicines which no longer required prescribing being stopped so the patient was not receiving unnecessary treatment.

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

Cleanliness and infection control

We observed that the premises were visibly clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients who completed comment cards had no concerns about cleanliness or infection control.

The practice had an identified infection control nurse lead who liaised with the clinical commissioning group's infection control nurse on best practice. We saw an audit of infection control had been carried out in December 2013 and no concerns were identified. The annual audit for December 2014 had been commenced. The lead nurse said they were responsible for delivering infection control training for reception and administration staff. This group of staff were not expected to manage spillages or samples, but spillage kits and protective clothing such as gloves were made available at the reception desk if needed. All staff received training on infection control during their induction and received annual updates.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap and towel dispensers were available in treatment rooms. Hand cleansing gel was available at the reception desk for patients to use with clear signage to prompt usage. Treatment rooms had supplies of personal protective equipment, such as gloves and aprons and there were designated 'sharps bins' for disposal of needles and syringes.

Legionella testing was carried out by the landlord of the premises.

Equipment

We saw that there was sufficient equipment for staff to carry out diagnostic examinations, such as blood pressure monitors. Equipment was maintained, tested and calibrated by an external company and we saw records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Equipment used for monitoring patients' blood sugar levels was calibrated weekly by nursing staff and recorded, this ensured that readings taken were accurate.

Staffing and recruitment

Records seen showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, registration with the appropriate professional body and satisfactory conduct in previous employment. The practice manager had a system in place for checking the Nursing and Midwifery Council registration numbers for nurses and dates had been entered in to a diary for the forthcoming year of when another check was needed. All nurses and GPs had had a criminal record check carried out via the Disclosure and Barring Service (DBS). Other members of staff had been risk assessed to determine whether a DBS check was needed.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix needed to meet patients' needs. We saw there was a rota system in place for the different staff groups to ensure that enough staff were on duty. Changes had been made when needed to cover sickness and annual leave. The lead GP told us

Good

Are services safe?

that they operated a credit system for GPs working at the practice, whereby a number of hours were made available by all GPs throughout the year to cover short term sickness, when locum cover could not be arranged.

Monitoring safety and 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 parts of the building that the practice occupied, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff, patients and visitors to see. We saw that fire alarms were tested on a weekly basis and recorded.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a patient's heart in an emergency). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for us. All the medicines we checked were in date and fit for use.

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 an emergency plan in place which detailed staff responsibilities should an incident occur, for example a power failure. There were details of emergency contacts for power supplies in the event of a power failure. Procedures were also in place to 'back up' the computer server system to ensure information was not lost in the event of a power failure.

Good

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 and from local commissioners. Information was discussed at monthly practice meetings and current guidance was disseminated to staff. When appropriate actions were agreed and taken, for example the practice had organised for a consultant who specialised in diabetes to talk at one of the meetings about current medicines available to treat diabetes. GPs also said that a medicines management meeting was held quarterly where guidance for treating conditions was discussed in line with best practice. An example given was treating atrial fibrillation (an abnormal heartbeat) by changing medicine to warfarin (warfarin works by thinning the blood which allows the heart to work more effectively).

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.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Staff we spoke with were very open about asking for and providing colleagues with advice and support. Patients who had conditions such as dementia had an annual review to ensure they were receiving the correct treatment and a plan of care was drawn up with the patients' involvement. We were shown three examples of patient care plans that were held on their records.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. If a patient had been required to attend accident and emergency or had been an inpatient in a hospital, the care received was reviewed by the patient's usual GP and action taken when needed. Minutes of meetings confirmed this had occurred.

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, managing child protection alerts and medicines management.

The practice has a system in place for completing clinical audit cycles. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Examples of clinical audits included medicines management, for example use of quinine, where patients who had been taking the medicine for a year were reviewed and the medicine was stopped if clinically appropriate.

The GP responsible for QOF said that they ran regular searches on the computer database to determine how well the practice was achieving outcomes expected. The information from these searches assisted the practice in taking action when needed to make sure they were monitoring patient outcomes effectively. The GP said that patients identified as requiring monitoring for their conditions, such as diabetes, were offered an annual review. If a patient did not keep the appointment then the practice would contact the patient in writing on three occasions and then via a telephone call from their usual GP to arrange a suitable time. Nurses also went to patients' homes to carry out QOF checks if the patient was unable to attend the practice.

We were shown examples of practice monitoring of patients with long term conditions. For example alerts were placed on patients' records if they were diagnosed with type 1 diabetes, to check for coeliac disease. Another example was the use of comprehensive care plans which documented procedures to avoid hospital admissions and an annual review of care and treatment.

The practice also worked with the university of Southampton on one research project a year, which usually focussed on health promotion.

Good

Are services effective?

(for example, treatment is effective)

Nursing staff were responsible for contacting parents of children who had not attended appointments for routine vaccinations. They said that they would discuss reasons for non-attendance with the parent and make a new appointment if needed.

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. They also checked that all routine health checks were completed for long term conditions such as diabetes and that the latest prescribing guidance was being used.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff had received training in basic life support, infection control, diabetes care and confidentiality. Training was provided in a variety of ways such as in house training, online training and shadowing other members of staff in the practice. One nurse said that a part of their induction they shadowed other nurses and had undertaken training on asthma care and the practice's triage system. They added that they had a personal development plan in place and had recently completed basic life support training, annual infection control training and significant event training. We also found that on occasion external clinicians were invited to give talks. Staff we spoke with confirmed that they had received a formal induction and further training, copies of which were shown to us on the shared drive of the computer systems.

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.

Staff performance was managed through informal discussion, improvement plans and personal development plans. The practice manager kept a file of notes of discussions held which contained any actions agreed. For example, one member of staff required extra support to carry out their role and there were details of meetings held and support given to enable the member of staff to work effectively. Another file showed that 360 degree feedback was used to monitor and assess performance. Staff said that this was an effective learning tool to use. All members of staff had received an annual appraisal and their learning needs identified had been planned for.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines and cervical smear testing. Those with extended roles for example, seeing patients with long term conditions such as chronic obstructive pulmonary disease (difficulty breathing) and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the patients who had complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, palliative care nurses and decisions about care planning were minuted and shared with all staff. We found that when needed a consultant geriatrician (a specialist doctor who cares for older patients) also attended the meetings to discuss patient care.

We spoke with the lead GP for palliative care (usually patients nearing the end of life), they explained that anticipatory care plans had been developed and were reviewed at least three monthly. We saw an example of one of the plans and found that there were details of the patient's specific needs and details of medical input. These

Good

Are services effective?

(for example, treatment is effective)

care plans were shared with out of hours providers. Palliative care meetings were held every two months and attended by Macmillan nurses and on occasion a consultant in palliative care.

The practice worked closely with four other GP practices in the area and had buddying arrangements in place for clinical and non-clinical staff. District nurses and health visitors were based nearby and interacted often with the practice which was evidenced in meeting minutes.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding addition information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

GPs told us that maternity services were midwife led and antenatal appointments were not routinely carried out at the practice due to the midwifery service being in the same grounds as the practice premises. They said that often they were not made aware of a woman's pregnancy as communication was not effective between the practice and the midwifes. GPs said that midwives had agreed to send information on a weekly basis to the practice but this had not occurred and this issue was on going.

Nurses told us that there were good shared care arrangements in place with local hospital for the treatment of leg ulcers. They considered that had improved the protocol followed and allowed patients to self-refer to the leg ulcer clinic at the local hospital.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. One staff member said there had been a recent power point presentation on this topic. Staff were able to describe how they would implement it in their practice and ensure patients were supported to make their own decisions. Staff were able to describe the process of involving other people, such as family members, and presenting information in a format that could be easily understood. For example, one member of staff said that if a patient had a learning disability they were able to access a web site where there were a range of pictures that could be used to assist these patients in decision making.

All GPs and nurses we spoke with were aware of Gillick competencies (these help GPs and nurses to identify children under 16 years old who have the capacity to consent to medical examination and treatment) and how to determine whether a young patient was able to consent independently. Staff said that when a child received routine vaccinations there were printed cards with space for recording consent and which included details of side effects. If a parent declined a vaccination for their child this was recorded.

Health promotion and prevention

The practice had several ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. Similar mechanisms of identifying at risk groups were used for patients who were receiving end of life care. These patients were offered further support in line with their needs.

The practice offered NHS health checks to all its patients aged 40-75. All patients age 75 years or older had been written to with details of their named GP.

The practice offered a full range of immunisations for children in line with national guidance. Travel vaccinations and flu vaccinations were also offered in line with current national guidance.

The practice website had details of other organisations or agencies that patients could access to obtain information on health and wellbeing. There was a television screen in the waiting area provided by the patient participation group on which a rolling slide show was displayed. This slide show included information on health promotion and keeping well, opening times of the practice and how to contact other health care providers.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had undertaken a patient survey between November and December 2013 and January to February 2014. Results from this survey showed that 66% of respondents said that the GP was very good at treating patients in a respectful manner and 21% thought GPs were good. A similar number considered that GPs were good at listening and they also felt that they had sufficient time in their appointments.

53% stated that GPs were very good at involving patients in decision making and 24% considered GPs were good at involving patients in decision making. A similar number considered this occurred in relation to GPs providing care or treatment. We spoke with eight patients who all said that they had no concerns about how they were treated. All 40 comment cards we received were positive about care and treatment received.

Patients said that reception staff did not ask personal questions and that their privacy and dignity was respected. Staff working in the practice had received training on equality and diversity, compassion, dignity and confidentiality. Staff were able to demonstrate these qualities in their everyday work. For example, we observed that patients were given sufficient time to talk with reception staff and telephones for the practice were situated away from the main desk. The national patient survey identified that patients were concerned that they could be overheard in the reception area. The practice reception area was open to the waiting area and the practice had as far as practicably possible reduced the likelihood of this occurring. For example, patients were requested to wait behind a designated spot until a receptionist was free to talk with them. Also, there was a private area where patients could speak in confidence if they requested to do so.

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 85% of practice respondents said the GP involved them in care decisions, which was higher than the national average. 81% felt the GP was good at explaining treatment and results; this result was marginally below average compared to the national average. However, 87% of patients described their overall experience of the practice as good or very good, which was above the national average. The results from the practice's own satisfaction survey showed that the majority of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health needs were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Patients considered that support was provided by the practice to cope emotionally with care and treatment. Comment cards we reviewed also aligned with the views of those patients we spoke with. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Patients were able to access clinics for long term conditions such as diabetes or asthma. Patients receiving palliative care were reviewed with other members of the multi-disciplinary team and the practice's end of life care registered was accessible to out of hours providers.

The next of kin of a recently deceased patient was send a letter from the surgery offering condolences and informing them of bereavement counselling services available from other providers. One GP said they would all try and visit the bereaved family or telephone them to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice said that they regularly engaged with the clinical commissioning group (CCG) and other GP practices in the area to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvement and made changes to the way it delivered services, for example, appointment times and availability, in response to feedback from the patient participation group (PPG). One of the PPG members said that a representative from their group normally attended the CCG meetings to gain information on health needs of the wider community and how these would be met by GP practices.

The practice did a search every month for patients who reached 75 and wrote to them informing them of their named GP.

Ante natal clinics were midwife led and GPs said they were concerned that information requested on a regular basis had not been provided and they were not always aware that a woman was pregnant until they visited the practice for another reason and could therefore not always provide holistic care.

The practice had a contract to provide palliative care to a local hospice. This consisted of a daily ward round on weekdays and a GP being on call to deal with any urgent needed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, there were dedicated baby changing and breastfeeding facilities available. Reception staff that when babies or children came for appointments if they were particularly distressed reception staff would instant message the GP to ask them to see patient sooner. We noted there were touch screen facilities for patients to register their arrival at the practice.

The practice was situated on the first floor of the building and was accessible by a lift. The PPG group said that they had organised for the main doors into the building to be made automatic and had made sure that wheelchair accessible toilet facilities were clearly signed in the practice. The waiting area was large enough to accommodate wheelchair users and prams and allowed for easy access to the treatment and consultation rooms. Treatment rooms had couches that could be raised or lowered in height to allow patients to sit or lie on them easily.

One GP told us there was a group of patients who were Nepalese. They said that at present no specific services were required, but were aware of translation service should communication become an issue. The practice website had the facility to translate its content into other languages.

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. Reception staff said that when needed specific telephone appointments times could be organised to fit in with a patient's working day. 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, online and in person to ensure they were able to access the practice at times and in ways that were convenient to them. Routine appointments were available from 8am to 6.30pm Monday to Friday. Extended hours surgeries were available from 7.30am to 8am on weekdays and from 6.30pm to 7pm on Mondays. These appointments were pre booked routine appointments with both GPs and nurses, however reception staff were available to deal with general enquires and prescription requests.

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 lead nurse monitored the demand for nurse appointments and was able to allocate extra nurses appointments if needed. Some patients said they found the

Good

Are services responsive to people's needs?

(for example, to feedback?)

telephone appointments useful and used the online services to book appointments. They had also noted an improvement in getting an appointment. The patients said that when they needed to be referred to a local hospital this was done quickly.

Baby and young children immunisation clinics were available twice weekly, but individual appointments could be arranged at other times to suit parents. Nurses and GPs said that the practice was flexible with the length of pre-bookable appointments and reception staff were able to book longer appointments when needed, for example if a patient was having dressing changed or had poor mental health.

The lead GP said that home visits for housebound or vulnerable patients were arranged geographically to minimise travel time for the GP and increase time efficiency.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. All complaints or concerns whether verbal or in writing were recorded and acted upon. There was a designated person responsible who handled all complaints in the practice. Records we looked at confirmed that action had been taken when needed to resolve the concern as far as practicably possible. We found that all complaints had been responded to, but the letters did not contain any information about advocacy services, the Ombudsman or the role of NHS England in complaints handling.

The practice held meetings every six months to identify themes and ensure corrective actions taken were on going. The practice manager said that all telephone calls to the practice were recorded and was frequently used to assess complaints and behaviour of staff. The practice manager kept recordings and invited complainants in to listen to the recording so they could discuss concerns together. An example given when this was used involved a member of staff whom a patient had thought had an abrupt manner. The outcome resulted in support being given to the member of staff to be aware of their manner when dealing with patients on the telephone. The practice manager said they often monitored how reception staff responded to telephone calls to ensure that patients were spoken with appropriately. Patients did not raise any concerns about how telephone calls were answered.

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

All staff said that there is a strong patient focus and provision of a good service to patients. During the practice presentation we were told that the vision and strategy of the practice was one of a democratic ethos and a happy and cohesive team with a focus on delivering high quality patient care. An example given was about the democratic nature of the partnership and the use of voting on decisions affecting the practice. One GP said that they could only recall one occasion many years ago when a decision had to go to a vote. All staff we spoke with were aware of this vision and said that they were included in decision making and worked to this ethos daily.

The practice had a statement of purpose in place, this required expanding and reviewing to be compliant with the regulations.

Governance arrangements

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 lead for safeguarding. All staff members were clear about their roles and responsibilities. They all said they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. (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, for example diabetes and implementing preventative measures. The results are published annually.) The QOF data for this practice showed it was performing in line or above with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. The practice had completed a number of clinical audits, for example medicines prescribing. Learning from these audits had taken place when needed and reviewed.

We found there were no overarching quality monitoring systems and central risk registers collated in place to monitor how the practice ran as a whole. We noted there were some risk assessments in place, for example fire safety, with actions needed and taken which were recorded. Similarly significant events and complaints were formally reviewed every six months to identify trends or themes, but these were not clearly recorded with an action plan to identify any emerging trends.

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 nurse said that they found GPs were encouraging and supportive. All GPs listened and would act when needed. Another nurse considered that triage system had allowed for more collaborative working between nurses and GPs and enabled on going discussions about care and treatment.

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

The practice had gathered feedback from patients through surveys and comments and complaints received. We looked at the results of the annual survey carried out by the patient participation group (PPG) in November /December 2013 and January/ February 2014. The survey was carried out virtually via email, as well as paper questionnaires. The main areas for improvement identified were concerning continuity of care and involvement in decisions. An action plan had been put into place and monitored. Members if the PPG told us a stand alone survey had been carried out in August 2014 to focus specifically on issues with appointment availability. As a result of this survey, changes had been made to availability of and type of appointments. Patients said that they had started to notice these improvements to the appointment system. In the PPG report there was factual information on a typical working day for a GP which allowed patients to understand the role of the GP. The PPG held monthly meetings and we were told that a GP always attended this meeting and listened to what the group had to say and worked collaboratively with them.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they felt engaged and involved in the practice to improve outcomes for both staff and patients. They said GPs and the practice manager were responsive and listened to their ideas and took action when needed.

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

Staff told us that the practice supported them to maintain their clinical professional development through training and the appraisal system. We looked at staff files and records and found all staff had received an annual appraisal and learning and development plans were in place. Staff said they did not have any formal one to one sessions but were able to approach the management team to discuss any concerns or areas for improvement.

We noted that information from significant events and complaints was shared with staff at their meetings and all staff were required to sign meeting minutes to show they had seen and read them.