Merstow Green 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 Merstow Green Medical Practice on 6 May 2015. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said 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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available on the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

We saw several areas of outstanding practice including:

- The practice organised IT training and support sessions in conjunction with the local library to train patients to use the practice's on-line systems, for example, how to book appointments. This has seen an increase in use of on-line appointment booking.

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- The practice directly employed its own counsellor for patients to be referred to as this was found to be more efficient than using external organisations. As a result the waiting time for appointments has been reduced by approximately three to four weeks.
- The most vulnerable patients (for example, those with learning difficulties or those with severe health needs) were given a medical alert card which they were encouraged to carry with them at all times. This gave an ex-directory phone number for the patient (or someone assisting the patient) to contact the 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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Patients' care and treatment took account of guidelines issued by the National Institute for Health and Care Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions. This included plans to avoid emergency admittance to hospital where possible. Areas of clinical practice were regularly audited. We saw cycles were completed regularly to measure the effectiveness of any improvements made. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement. The practice also directly employed its own counsellor to whom patients could be referred.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. This included audits of patient demand to ensure there was enough

Summary of findings

capacity to meet patients' needs. Patients reported good access to the practice and said that urgent appointments were available the same day. There was also a daily minor illness clinic with appointments that could be booked each day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. The practice was regularly involved with trials of new medicines to improve outcomes for patients.

Are services well-led?

Good

The practice is rated as good for being well-led. The senior GP partner had a lead role for governance. The practice had a clear vision with quality and safety as a high priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. The most vulnerable patients were given a medical alert card which they were encouraged to carry with them at all times. This gave an ex-directory phone number for the patient (or someone assisting the patient) to contact the practice. The GPs and practice nurses carried out visits to patients' homes if they were unable to travel to the practice for appointments. Clinical staff also carried out weekly 'rounds' of two local care homes. Staff in these care homes had an ex-directory telephone number to use to contact the practice. Patients who had been admitted to hospital due to a fall always received a follow up visit with other agencies involved if required. Flu and pneumonia vaccination clinics were provided with evening and weekend appointments available.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD). Members of the GP and nursing team at the practice ran these clinics. The local district nursing team were contracted by the practice to provide a clinic for patients with leg ulcers. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. Patients told us they were seen regularly to help them manage their health. At the time of our inspection, the practice had just completed offering flu vaccinations to people with long term conditions.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics. This included appointments outside of school hours and its rates of immunisation for children was above average for the South Worcestershire Clinical Commissioning Group (CCG). Weekly

Summary of findings

antenatal, baby and children's clinics and minor ailments clinics were also held. The practice provided cervical screening and a family planning service. A health visitor was based within the practice.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. All patients had a named GP irrespective of their age. The practice provided extended opening hours until 7.30pm on Wednesdays and Thursdays. The practice also opened when needed on Saturday mornings if there had been patients unable to attend during the week. Clinics for vaccinations were also provided during these times. NHS health checks were carried out for patients aged 40 to75. At the time of our inspection these had also started to be offered outside of regular working hours. The practice referred patients to the smoking cessation support.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. Regular reviews were carried out in conjunction with community nurses and matrons. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff were aware of safeguarding procedures and GPs told us how alerts were placed on the records of potentially vulnerable patients. The most vulnerable patients (for example, those with learning difficulties) were given a medical alert card which they were encouraged to carry with them at all times. This gave an ex-directory phone number for the patient (or someone assisting the patient) to contact the practice. Patients with a drug addiction were cared for with a 'shared care' approach with appropriate agencies.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the community mental health team, social services staff and the local Gateway mental health service. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice carried out dementia screening.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at nine CQC comment cards patients had filled in and by speaking in person with eight patients. This included two patients who were members of the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

All patients we spoke with and received comment cards from were happy with the care they received from Merstow Green Medical Practice. Patients said GPs and practice nurses respected them and were always helpful and friendly. Six patients commented on how caring staff were. Some patients we spoke with had been patients at the practice for a number of years and two of the patients told us the practice had always provided a consistently good service. Some patients we spoke with had recommended the practice to friends and family. Five patients we spoke with said they found it difficult to get appointments at times, but could always get one in an emergency. Three patients said they could always easily get an appointment.

Data available from the 2014 GP national patient survey showed that the practice scored broadly average within the South Worcestershire Clinical Commissioning Group (CCG) for satisfaction with the practice, although some areas were below average. For example, 95% of respondents say the last GP they saw or spoke to was good at treating them with care and concern, against a CCG average of 89%; 68% of respondents with a preferred GP usually got to see or speak to that GP, slightly above the CCG average of 66%; 47% of respondents found it easy to get through to this surgery by phone, below the CCG average of 77% and 66% of respondents described their experience of making an appointment as good, below the CCG average of 78%.

Management at the care homes served by the practice told us the practice provided an excellent standard of service and consistent care for their residents.

Outstanding practice

- The practice organised IT training and support sessions in conjunction with the local library to train patients to use the practice's on-line systems, for example, how to book appointments. This has seen an increase in use of on-line appointment booking.
- The practice directly employed its own counsellor for patients to be referred to as this was found to be more efficient than using external organisations. As a result the waiting time for appointments has been reduced by approximately three to four weeks.
- The most vulnerable patients (for example, those with learning difficulties or those with severe health needs) were given a medical alert card which they were encouraged to carry with them at all times. This gave an ex-directory phone number for the patient (or someone assisting the patient) to contact the practice.

Merstow Green Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to Merstow Green Medical Practice

Merstow Green Medical Practice is located in Evesham. The practice has occupied its current purpose built facility since 2007. It currently has 10,800 patients registered. The practice also has a dispensary which can used by patients who live more than one mile away from the practice, in line with national guidance.

Evesham is a small town with a higher than average rate of employment. There are some localised areas of deprivation and most patients speak English as their first language. The practice has slightly lower than average numbers of patients with long term medical conditions, although there is a high elderly population. This includes some with dementia, some of whom are resident in the two care homes looked after by the practice.

Merstow Green Medical Practice offers a range of NHS services including an antenatal clinic run by a community midwife, NHS health checks, minor ailments clinics and also employs its own counsellor for patients. Minor surgery is carried out at the practice and there is also a dispensary which can be used by patients who live over one mile away. A chaperone service is available for patients who request the service. This is advertised throughout the practice.

The practice has three full time GP partners, four part time GP partners and one full time associate GP. These are a mix of male and female. At the time of our inspection the practice was recruiting for an additional full time salaried GP with a view to them becoming a partner later. Four practice nurses and five healthcare assistants complete the clinical team. Clinical staff are supported by a practice manager, a patient liaison manager and a team of administrative, reception and dispensary staff. A patient counsellor was also directly employed. Merstow Green Medical Practice also hosts students studying to attend medical school. The practice has a General Medical Services (GMS) contract with NHS England.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we reviewed before the inspection we had no concerns about the practice. The data we reviewed showed that the practice was achieving results that were average or in some areas slightly above average with South Worcestershire Clinical Commissioning Group (CCG).

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider was previously inspected under our previous inspection programme in August 2013. They had not been inspected under our new inspection programme and that was why we included them.

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.

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 this inspection, we reviewed a range of information we held about Merstow Green Medical Practice and asked other organisations to share what they knew. These organisations included South Worcestershire Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 6 May 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with eight patients who used the service. This included two members of the Patient Participation Group (PPG).

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a variety of information to identify risks within the practice and improve safety for patients. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns, and discussed the procedure of reporting events and near misses. For example, we saw how staff had reported an incident involving the timeliness of a child safeguarding referral The procedure for incidents of this nature was reviewed and steps put in place to ensure staff were clearer about the action that should be taken in the future.

During our inspection, we examined safety records, incident reports and minutes of meetings where incidents had been discussed, for the last twelve months. This showed the practice had managed these consistently and could show evidence of a safe track record. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind. For example, a clinical audit of patients with COPD (the name for a collection of lung diseases including chronic bronchitis, emphysema) and asthma was carried out in April 2014 and again early in 2015. This examined their medication and inhaler technique. This identified two patients who needed their medication to be changed and three who needed a reduced dosage. Changes identified were then implemented when patients with these long term conditions received their annual reviews.

Learning and improvement from safety incidents

The practice had the required systems in place for the reporting, recording and monitoring of all significant events, incidents and accidents. We were shown the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with practice policy. During our inspection we examined and reviewed records of significant events that had occurred over the last twelve months. We saw that significant events and complaints were reviewed and discussed at practice meetings.

We reviewed one such incident regarding the issue of anti-depressant medicines. A repeat prescription had been issued without an overdue medicines review having been carried out with the patient beforehand. As a result, the practice changed its procedure for issuing repeat prescriptions for anti-depressants. All patient requests were passed to the patient's named GP for approval instead of going to the duty GP each day with other repeat prescription requests for signing. The dispensary also checked any such repeat prescriptions it had received had been approved according to this procedure. This demonstrated the practice had learned from the incident and we were satisfied this had been discussed and shared with relevant staff. The practice was able to demonstrate that all safety incidents were correctly identified, recorded and reviewed. We saw that staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at staff meetings. National patient safety alerts were also discussed in staff meetings with practice staff.

Reliable safety systems and processes including safeguarding

There were systems used by the practice to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for relevant agencies were easily available to staff. The practice had reviewed safeguarding procedures within the last 12 months following the failure of a child to attend for an appointment with a locum GP. There was then a delay with the practice making a safeguarding referral. During our inspection we saw that safeguarding concerns were regularly highlighted and discussed at team meetings and GPs told us safeguarding alerts were placed on the records of vulnerable patients.

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children with a deputy appointed to act in their absence. They had received appropriate training. All staff we spoke with were aware who the lead

was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority.

A chaperone policy was in place, which was visible on the waiting room noticeboard 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. We saw records that demonstrated nursing staff and some reception staff had been trained to be a chaperone. Risk assessments had been carried out for this. Staff we spoke with understood the requirements of the role.

There were also systems in place to identify potential areas of concern. For example, for clinical staff to identify children and young people with a high number of accident and emergency attendances and follow up of children who failed to attend appointments such as childhood immunisations.

Medicines management

During our inspection, 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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw that practice staff followed this policy. There were also processes in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw there were national guidelines in place to support the nursing staff in the administration of vaccines. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

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 as these were tracked through the practice and kept securely at all times. We reviewed the details of one incident where a blank prescription pad had been mislaid. Following this, the procedure for prescription pads had been reviewed and all staff reminded of their responsibilities in relation to this.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If this had not been done, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. Dispensary staff checked that all repeat prescriptions for anti-depressants were signed by the patient's named GP rather than by the duty doctor for that day. We saw these processes were working in practice. The practice had established a service for patients to pick up their dispensed prescriptions and had systems in place to monitor how these medicines were collected. The practice had also signed up to the electronic prescription service.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The dispensary also held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the disposal of controlled drugs. Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

During our inspection, we noted the practice was clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice used a contract cleaner and we saw a service level agreement was in place to monitor the performance of this contract. Relevant

information about Control of Substances Hazardous to Health (COSHH) was clearly displayed within the cleaning cupboard. One of the patients we spoke with commented on how spotless the practice was at all times.

A practice nurse was the infection control lead within the practice who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates We saw evidence the infection control lead had carried out an infection control audit in April 2015. No action points were needed as a result of this and in previous years any improvements identified were quickly completed .

An infection control policy with supporting procedures were available for staff to refer to. This enabled staff to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in December 2014.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. We reviewed an incident when sharps were spilled out of a clinical waste container into the car park. As a result of this, a new procedure was introduced to ensure external bins were correctly assembled and secured.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw portable electrical equipment was routinely tested and appliances we examined displayed stickers indicating the last testing date, March 2015. A schedule for the testing and calibration of relevant equipment was in place.

Staffing & Recruitment

The practice demonstrated how they ensured sufficient staff with the correct mix of qualifications and skills were on duty whenever the practice was open. A staff rota was used throughout the week and there always a member of clinical staff on duty. Some administrative staff were part time and able to work additional hours to provide staff cover if a staff member was unexpectedly absent.

The practice regularly reviewed their staffing needs to ensure sufficient staff were available throughout each week to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. There was guidance available for staff about expected and unexpected changing circumstances. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences.

There was a business continuity plan in place which gave guidance on what to do if there was a shortage of GPs or practice staff due to sickness for example. This included arrangements for using locum GPs. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. This detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out to confirm this. We looked at a selection of recruitment files for GPs, administrative staff and nurses and were satisfied the recruitment procedure had been followed.

Good

Are services safe?

In addition, the practice regularly hosted students studying to attend medical school. We saw how they were given appropriate training and supervision within the practice.

Monitoring safety and responding to risk

The practice had appropriate processes and policies in place to manage and monitor risks to patients, staff and visitors. This included regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role. All identified risks were included on a risk log. Each risk was assessed and rated and 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 or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training and regular updates in basic life support. There was emergency equipment available to use if a medical emergency occurred. This included oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff knew where this equipment was kept and we saw records to confirm it was regularly checked, There were also emergency medicines kept in a secure area of the practice. They included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had last been reviewed in April 2015. Management confirmed copies of this were kept at the homes of GPs and practice management. Risks identified included power failure, adverse weather including flooding and access to the building. If the practice building became unusable, a control centre would be established in the home of the senior GP partner and alternative premises had been identified to use as a temporary practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

During our inspection, we were told how by staff and patients how patients' needs were assessed and care and treatment was planned and delivered in line with their individual preferences. All patients we spoke with were happy with the care they received and any follow-up needed once they obtained an appointment and said GPs and practice staff gave them excellent care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis and audits of these reviews had been carried out.

Every patient newly discharged from hospital was given a telephone consultation and assessed as to their need for a care plan or onward referral or signposting. Patients who had been admitted to hospital due to a fall always received a follow up visit with other agencies involved if required.

Those patients who required palliative care (palliative care is an holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff were trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included minor surgery, referrals to secondary healthcare services (for example, hospital) and COPD. Some of this monitoring was carried out as part of 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 such as diabetes and implementing preventative measures. The results are published annually. The practice's performance was 95.9%, similar to the average for the South Worcestershire Clinical Commissioning Group (CCG) at 96.07%. (The CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.)

Patients with long term conditions were regularly reviewed by the clinical team. We were shown that during the last 12 months, 100% of patients with a learning disability, 83% of patients with dementia, 82% of patients with poor mental health and 82% of patients who received palliative care had been reviewed. Of those patients entitled to receive the flu vaccination (3569), 72% were vaccinated during the 2014/2015 programme.

Effective staffing

Staff employed at the practice included medical, nursing, managerial and administrative staff. We examined staff training records and saw that all staff were up to date with attending courses such as annual basic life support and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and 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).

We were shown that all staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Clinical staff based at the practice had access to a senior GP for support when needed.

Practice nurses had clearly defined duties which were outlined in their job description and were able to

Good

Are services effective?

(for example, treatment is effective)

demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates 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.

The practice held team meetings every month to discuss concerns, for example, any incidents and complaints that had occurred, the needs of complex patients, those with end of life care needs or children who were at risk of harm. These meetings were attended by district nurses, social workers, palliative care nurses when appropriate and any decisions made about care planning were documented. Weekly dedicated palliative care meetings were also held. Clinical staff and the GP partners met regularly outside practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified. At the time of our inspection, the practice had arranged to provide office space for the Social Services Enhanced Care Team to move into. This avoided the team having to be moved to Worcester following a local authority re-organisation and enabled a locally based team to be maintained with a close, local, working relationship.

Within the practice, clinics were held for blood testing, hypertension (high blood pressure), diabetes and minor surgery amongst others, to which patients were referred when appropriate. The local district nursing service had also been contracted by the practice to provide a regular clinic for patients with leg ulcers.

We saw there was a large range of information leaflets about local services in the waiting room. Most of this was in English due to the low numbers of patients who did not speak English as a first language. We were told information could be provided in other languages when needed. Relevant information was also displayed on a screen within the patient waiting room.

Information sharing

The practice used several electronic systems to communicate with other providers. 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, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency (A&E) department.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

Merstow Green Medical Practice had processes in place to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We also saw evidence that audits of minor surgery consent were carried out.

We saw the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Good

Are services effective?

(for example, treatment is effective)

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Most of the patients registered with the practice spoke English as a first language, however staff explained how an interpretation service could be used to ensure patients understood procedures if their first language was not English.

Health Promotion & Prevention

We saw all new patients were initially offered an appointment with the patient liaison manager when they wished to register at the practice. The patient liaison manager discussed the services available at the practice and assessed whether the patient had any additional needs. They were then offered a consultation with a practice nurse. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40 to75. The uptake for these was low at 13%. The practice had identified this and at the time of our inspection had started to offer them outside of regular working hours. This had improved patient take up. Practice staff told us they would continue to closely monitor this to ensure the uptake for health checks remained consistent.

The practice's performance for cervical smear uptake was above average at 91.1% compared to the CCG average of 80.1%. Smoking cessation advice was also offered. At the time of our inspection, the practice had 3122 patients who smoked. All had been offered cessation advice within the last 12 months. As a result, 336 had stopped smoking, 11% of the total.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with and patient comment cards we received were complimentary about the care given by the practice and any follow-up needed once patients had obtained an appointment. All patients felt they were always treated with respect and dignity by all members of staff. Patients commented on how professional, friendly and helpful GPs and staff were. Six patients we spoke with or who completed comments cards specifically mentioned how caring the practice was.

During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients. Staff we spoke with told us excellent patient care was crucial and their behaviours displayed this at all times. The 2014 GP National Patient Survey results showed that 96% of patients said the last GP they saw or spoke with was good at listening to them. This was above the average of 92% for the South Worcestershire Clinical Commissioning Group (CCG). A total of 87% of patients said the last GP they saw or spoke with gave them enough time. This was slightly below the CCG average of 90%. (CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.)

We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at and discussed patient choice and involvement. Clinical staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. We were also told how they discussed any proposed changes to a patients' treatment or medication with them beforehand. Eight patients we spoke with confirmed this. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with also confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs. Some patients we spoke with had long term conditions and they told us they were seen regularly.

The 2014 GP National Patient Survey results showed that 96% of patients said the last GP they saw or spoke with was good at explaining tests and treatments. This was above the CCG average of 90%. A total of 89% of patients said the last GP they saw or spoke with was good at involving them in decisions about their care. This was above the average of 86% for the CCG.

Patient/carer support to cope emotionally with care and treatment

On this occasion, we did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provide for carers and links to refer patients to appropriate organisations, including the practice counsellor for professional support. The practice directly employed its own counsellor for patients to be referred to as this was found to be more efficient than using external organisations. Information was provided about organisations specialising in providing bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found Merstow Green Medical Practice to be responsive to patients' needs and had appropriate systems in place to maintain the level of service provided. All patients registered at the practice had a named GP irrespective of their age. The needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. For example, 2.3% of patients had a care plan in place. This enabled multi-agency care to be more effectively managed.

The most vulnerable patients were given a medical alert card which they were encouraged to carry with them at all times. This gave an ex-directory phone number for the patient (or someone assisting the patient) to contact the practice. Care homes served by the practice also had an ex-directory telephone number to use to contact the practice. The practice also enabled homeless people and travellers to register as patients to enable them to access NHS services. Practice services were also reviewed in the wider context of the local health community. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand.

The practice had an established 'virtual' (on-line based) Patient Participation Group (PPG). This was a group of patients registered with a practice who work with the practice to improve services and the quality of care. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular on-line discussions were held. We saw how the PPG had been involved with discussions to implement on-line appointment booking, the training for it and with the practice patient survey.

Tackling inequity and promoting equality

Most of the patients registered at the practice spoke English as their first language. The practice had access to an interpretation service if this was needed. Literature could also be made available in other languages if required.

Travellers and homeless people could also register at the practice to allow them to access NHS services. The practice was a modern building, designed with full accessibility in mind. This included an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible.

Access to the service

Appointments were available from 8am to 6.30pm from Monday to Friday. The practice provided extended opening hours until 7.30pm on Wednesdays and Thursdays. The practice also opened when needed on Saturday mornings if there had been patients unable to attend during the week.Telephone consultations were also provided. Patients were always seen or given a telephone consultation on the same day when this was necessary. When the GP telephoned a patient, if they decided the patient needed to be seen the same day they would be called into the practice. Outside of these times and during the weekend, an out of hours service was provided by another organisation and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside the practice's opening hours.

Appointments could be booked for the same day, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. This had only been introduced from February 2015 and was still being developed at the time of our inspection. However, the practice actively promoted this within the practice and through the local library with the patient training sessions that were available. Home visits were available for patients who were unable to go to the practice.

The 2014 GP National Patient Survey results demonstrated that 44% of patients who responded said they found it easy to get through to the practice by telephone. This was against an average for the South Worcestershire CCG of 76%. Additionally, 64% of patients described their experience of making an appointment as good. The CCG average was 78%. In addition, the practice carried out its own patient survey between January and March 2014. A total of 127 patients responded, 1.1% of the patient list. This revealed patients still experienced difficulty getting through to the practice. Four of the patients we spoke with or who completed comment cards in advance of our inspection made similar comments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Following these patient surveys, the practice made a number of changes. An audit of patient capacity and demand was carried out in conjunction with an external company. As a result, changes were made to appointment times and availability of clinical staff. For example, GP cover was also increased on Mondays. Telephone monitoring software was introduced and reception was restructured to accommodate the role of the patient liaison manager, with responsibility for the training and development of the reception team. The practice also introduced on-line appointment booking for patients from February 2015. The practice also organised IT training and support sessions in conjunction with the local library to train patients to use the practice's on-line systems, for example, how to book appointments. The practice put plans in place to review progress made at regular intervals.

Listening and learning from concerns & complaints

Merstow Green Medical Practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

We looked to see whether the practice adhered to its complaints policy. The practice had received four formal complaints within the last twelve months. We reviewed all four complaints. Two of these related to concerns about secondary healthcare and were responded to in conjunction with the other services involved. One remaining complaint concerned an inability to obtain an appointment. The patient was contacted and the matter resolved. The final and most recent complaint was from a patient who felt the on-line appointment booking system was not user friendly. The patient was invited into the practice for one-to-one tuition on the system. We found all complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given an explanation and when appropriate, an apology. The complaints policy also gave patients the opportunity to contact Healthwatch about any concerns. It was also clear from staff that verbal complaints were dealt with in the same way as written complaints.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice aimed to provide all patients with a high standard of personal, caring family medicine within the resources available and to deal with any problems as quickly and efficiently as possible. This was displayed on the practice website and in literature produced by the practice. GPs and staff we spoke with mentioned these values and demonstrated how their role impacted upon this.

GPs demonstrated how the practice kept up to date with research and governance recommendations and communicated these to staff accordingly. We also saw how the GP partners reviewed significant events, initiated and reviewed clinical audits and provided clinical management. In discussion with staff, it was apparent that the team at the practice had a clear vision to provide patients with a safe and caring service where patients were treated with dignity and respect.

The GP partners held regular partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. The practice regularly reviewed these objectives at staff meetings. The GP partners told us they wished to expand their team and were currently recruiting for a full time salaried GP with the aim of them becoming a partner at a later stage.

GPs told us how demand for services increased and how they sought ways to meet this demand wherever possible. This included the introduction and expansion of on-line services for patients. The practice had also sought and successfully received funding from the Prime Minister's Challenge Fund to provide extended opening hours.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. One of the GP partners had been appointed to the role of managing partner to oversee the governance and clinical management of the practice. Policies were in place to support these responsibilities. During our inspection we found that all members of the team we spoke with understood these roles.

The GPs and management of Merstow Green Medical Practice explained how they had created and wished to continue with a culture of openness and transparency. The practice held a weekly meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues. Opportunities were sought to expand the partnership team whenever appropriate and ensure a balanced mix of skills and interests was maintained.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the South Worcestershire Clinical Commissioning Group (CCG) to help them assess and monitor 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 such as diabetes and implementing preventative measures. The results are published annually. The practice's overall performance was similar to the CCG's.

Leadership, openness and transparency

The practice had a team of GP partners, some of whom had worked together over a number of years to provide consistent leadership. They were supported by a practice manager and patient liaison manager. All staff we spoke with described GPs and management as being very approachable and had no concerns about any aspect of the practice, its staffing or relationship with patients. Staff told us the practice was a great place to work and there were excellent working relationships within the team.

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

The practice had a 'virtual' Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care. This operated as an on-line group and information and points for discussion were regularly circulated amongst its members. This ensured patient views were included in the design and delivery of the service. We spoke with two members of the PPG and they explained how they had been involved with the practice patient survey and the introduction and training for patient on-line services.

Are services well-led?

Good

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

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. The 2014 National GP Patient Survey revealed that 85% of patients would recommend the practice to someone new to the area. This was just above the CCG average of 84%.

We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a staff development programme for all staff within the practice which was linked to their annual appraisal. The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.

The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such as emergency first aid and asthma were covered.