

St Mary's Road Surgery

Quality Report

St Mary's Road, Berkshire, Newbury, RG14 1EQ
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

Detailed findings from this inspection

Our inspection team	9
Background to St Mary's Road Surgery	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11
Action we have told the provider to take	23

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of the St Mary's Road Surgery on 13 June 2015. Overall the practice is rated as good.

We found the practice to be good for providing effective, caring, well-led and responsive services. It required improvement for providing safe services. It was good at providing services for all the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Risks to patients were assessed and well managed.

We saw one area of outstanding practice:

- The practice offered in house ultrasound service to patients. Two GPs were trained to offer this service and

Summary of findings

were able to carry out scans for pregnant women in early pregnancy and identify any problems quickly and efficiently. This also meant patients did not have to be referred to local hospital to access this service.

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

Importantly the provider must:

- Ensure all staff identified as requiring a criminal records check through the Disclosure and Barring Service (DBS) have one undertaken as soon as possible.
- Ensure all recruitment and employment information required by the regulations are documented in all staff members' personnel files.
- Ensure all relevant risk assessments are completed. This includes risk assessments in areas such as, fire, legionella and infection control.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. This was because recruitment and employment information required by the regulations was not documented in all staff members' personnel files. The practice had not completed Disclosure and Barring Service (DBS) checks for appropriate staff. Relevant risk assessments had not been completed. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patient feedback on access was generally positive; with some patients' commenting it was easy to get an appointment. Some patients said it was difficult to get appointment with their named GP and others said it was difficult to get through the telephone system.

Good



Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice sought feedback from staff and patients, which it acted on. The practice had patient participation group (PPG) in place. Staff had received inductions, regular performance reviews and attended staff meetings.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. 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 dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held regular clinics for long terms conditions such as asthma, diabetes and blood pressure and coronary heart disease.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young patients. The practice offered in house ultrasound service to patients. Two GPs were trained to offer this service and were able to carry out scans for pregnant women in early pregnancy and identify any problems quickly and efficiently. The practice ran regular clinics to support this population group, which included contraceptive, sexual health and child immunisations clinics. The practice had achieved the national average for childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Staff knew their patient population very well and the practice had systems in place to identify children or parents at risk. The practice held regular safeguarding meetings, where child protection issues were discussed and learning was shared. Children and young patients were treated in an age appropriate way and their consent to treatment using appropriate methods was requested.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and 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 patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice held regular palliative care and safeguarding meetings, where vulnerable patients were discussed. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Leaflets about local support groups were available and referrals to the memory clinic for patients with dementia were made. The practice also referred these patients to local charitable organisations, who offered patients with mental health support and advice.

Summary of findings

What people who use the service say

We spoke with 23 patients which also included members of the patient participation group (PPG). A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements can be made.

Patients we spoke with were positive about the service they received from the practice. Patients told us they felt involved and supported in decisions about their care and were given a caring service. Patients said they were given a wide range of information about their medical condition by the GP or the nurse. Most patients told us it was relatively easy to make appointments.

We received further feedback from twenty five patients via comment cards. The comments cards reviewed were generally positive. Patients commented staff were caring and kind and treated them with compassion. Two

comments received were less positive, one patient commented they were unable to get an appointment with their named GP and the other patient said they had difficulties in getting an appointment.

The practice results for the national GP patient survey 2014 were within the clinical commissioning group (CCG) and national average. Ninety five per cent of patients said the reception staff were helpful and 88% of patients found it easy to get through to the surgery by phone. Both these results were higher than the CCG average. Ninety one per cent of patients said the last appointment they got was convenient and 92% of patients said they were able to get an appointment to see someone the last time they tried. Seventy four per cent of patients described their overall experience of this surgery as good.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff identified as requiring a criminal records check through the Disclosure and Barring Service (DBS) have one undertaken as soon as possible.
- Ensure all recruitment and employment information required by the regulations are documented in all staff members' personnel files.
- Ensure all relevant risk assessments are completed. This includes risk assessments in areas such as, fire, legionella and infection control.

St Mary's Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St Mary's Road Surgery

The St Mary's Road surgery provides general medical services to approximately 11,800 registered patients. The St Mary's Road Surgery has a high number of patients registered who are over the age of 65 years old, with low deprivation scores.

Care and treatment is delivered by two male GPs and three female GPs practice nurses, health care assistants and phlebotomists. The practice also works closely with midwives, district nurses and health visitors. All consulting and treatment rooms are located on the ground floor.

St Mary's Road Surgery is open between 8am and 6.30pm on Monday to Friday and offers extended hours on alternate Tuesdays, Wednesdays and Fridays between 7am to 8am and 6.30pm to 8pm.

The practice is registered to provide the following regulated activities; family planning, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

The practice has a General Medical Services (GMS) contract. GMS contracts are subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

There were no previous performance issues or concerns about this practice prior to our inspection. This was a comprehensive inspection.

The practice is a GP training practice.

The practice provides services from the following site:

St Mary's Road Surgery

St Mary's Road

Berkshire

Newbury

RG14 1EQ

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.

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

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback.

Detailed findings

This included information from the clinical commissioning group (CCG), Chiltern Healthwatch, NHS England and Public Health England. We visited St Mary's Road Surgery on 13 June 2015. During the inspection we spoke with GPs, nurses, the practice manager, reception and administrative staff. We obtained patient feedback by speaking with patients, from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We reviewed documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a pregnant lady attending surgery slipped on tiles near entrance to building. Nurse was able to see her immediately and there were no injuries. We evidenced incident was reported and investigated professionally, and learning shared with team. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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 had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events that had occurred during the last 15 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and regularly discussed during weekly clinical meetings as and when required. We saw evidence to confirm that comprehensive annual audits were held for 2014 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.

Blank incident and significant events forms were available at the reception and in staff common room. Staff also used incident forms on the practice and sent completed forms to the practice manager. Staff showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared during team

meetings. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

Reliable safety systems and processes including safeguarding

The practice had systems 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 in-house training on safeguarding in children but there was no formal evidence of safeguarding training in adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities 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 were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. Most of the staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw examples of how the system flagged patients who may be at risk of abuse, and we witnessed message appeared on screen when accessing records for vulnerable adults from care homes.

There was a chaperone policy, 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). All nursing staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had not received Disclosure and Barring Service (DBS) checks (DBS checks

Are services safe?

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) and there was no risk assessment in place.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of at local chemist.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. The nurses administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, staff we spoke with informed us that gloves were used for all patients and aprons were used for smear and leg ulcer patients.

The practice had a lead for infection control who had not undertaken further training specific to their role 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 annual updates. We saw no evidence of infection control audits.

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 not undertaken a full risk assessment for legionella (a bacterium which can contaminate water systems in buildings) and no testing on water supplies was undertaken.

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 13 December 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, ultrasound scanner and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at did not contain sufficient evidence that appropriate recruitment checks

Are services safe?

had been undertaken prior to employment. For example, we were not able to find proof of identification, references, health checks and the appropriate checks through the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice had not undertaken a full risk assessment for fire and building safety and no risk log was maintained. Fire drills were carried out twice a year and fire extinguishers were regularly checked by approved contractor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received in-house training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice did not have a fire risk assessment in place but staff we spoke with were aware of fire safety. Records showed that staff were up to date with in-house fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found care and treatment was delivered in line with CCG and recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and for ovarian cancer diagnosis. Clinical staff told us any updates were circulated and reviewed by the clinicians, changes made as required and these were discussed at the team meetings as appropriate. 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.

We saw that GPs took a lead in specialist clinical areas such as palliative care, diabetes, dermatology and chronic obstructive pulmonary disease (COPD). There was evidence that the lead GPs in each area had received appropriate additional training to carry out their roles. For example, two GPs had completed diplomas in dermatology and palliative medicine and another GP had completed a training course in care planning. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice had registers for patients needing palliative care and for patients with learning disability. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. Monthly multi-disciplinary team meetings were held and they included other professionals involved in the individual patient's care.

All GPs we spoke with used national standards for urgent referrals seen within two weeks, and we saw national templates were saved on the shared drive for easy access. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was used by the GPs to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audits. These included completed cycle audits for UTI infection, audit of serum urate levels in gout patients and an audit on prevention of VTE recurrence after discontinuation of anticoagulation therapy. For example we reviewed the 'Urinary Tract Infection diagnosis and prescribing audit'. The aim of this audit was to see if an appropriate assessment had been made and if appropriate antibiotics had been prescribed, in a suitable dose and for a suitable duration. The second audit resulted in an improvement in standard of care, although the results relating to appropriate assessment and duration of treatment did not meet the national standards. Following the results of this audit, the clinical team discussed the key findings and gained knowledge about the current standards of care in diagnosing and managing UTI. We saw evidence learning was shared with all GPs in a clinical meeting.

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

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and keep up to date. They also regularly carried out clinical audits on their results and used that in their learning.

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people. We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included diabetes and COPD, diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance.

The practice routinely collected information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for

Are services effective?

(for example, treatment is effective)

the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice achieved 99% on their QOF 2014 score compared to a national average of 96%. Data from the QOF showed how the practice had performed well on areas including cervical screening and palliative care.

Effective staffing

All GPs had undertaken regular annual appraisals and either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) GP continue to practice and remain on the performers list with NHS England). The nursing team had been appraised annually. We saw learning needs had been identified and documented action plans were in place to address these.

Staff told us the practice was supportive in providing training that been identified. For example, one staff member told us they had completed training on diabetes. The training record made available to us showed staff had received training in areas such as, safeguarding, basic life support, infection control, fire safety and information security.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the GPs and nurses on the internal computer system.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were aware of their responsibility 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.

The practice held multidisciplinary team meetings once a month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors and decisions about care planning were documented in the meeting minutes. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice used the risk stratification tool to identify patients who were at risk of hospital admission and a register is kept to monitor this. Each patient identified were informed in writing about the register and provided with special telephone line they could use if they needed to contact the practice.

The practice had also signed up to community enhanced service for care homes. The aim of this project was to enhance the quality of medical care and treatment provided to all residents of registered care homes. Each patient had a comprehensive care plan in place and this was reviewed every six months. Each GP was responsible for a care home, and this developed better communication between the practice and the care homes.

The practice worked closely with the community matron and discussed individual patient needs. The practice aimed to minimise hospital admissions by working closely with other health professionals.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made 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

Are services effective?

(for example, treatment is effective)

in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

All the GPs worked full time and thus were able to have frequent communication throughout the day. The GPs also had many regular informal discussions and used this forum to share information.

The PPG produced a newsletter to share information of the developments within the practice. We saw a copy of the October 2014 newsletter, included information such as, appointments, the practice move to new premises, care plans, cancellations, online booking and alcohol consumption.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

The clinical staff spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Health promotion and prevention

A wide range of information about various medical conditions was accessible to patients from the practice

clinicians, the practice website and prominently displayed in the waiting areas. Health information was also displayed on the waiting room screen, which included information such as, important on regular exercise, consuming alcohol in moderation and smoking cessation.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register for patients with mental health problems and learning disability.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, in March 2015 the practice had sent fliers to all patients who smoked to inform them about the local stop smoking service. Patients were referred to weight loss programmes, and GPs appropriate referrals to meet the patient's needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was approximately 95% and was above average for the CCG. There was a clear policy for following up non-attenders by the practice nurse. In 2013/14 the practice vaccinated 73.1% of patients over 65 years old with the flu vaccine. This was higher than the national average of 72.99%. For patients within the at risk groups, 56.81% of patients were vaccinated in the same period. This was better than the national average of 53.22%.

In 2013/14 the number of patients with a smoking status recorded in their records was 86.11% which was slightly lower than the CCG and England average of 86.63. Of these patients 96.97% of patients had received advice and support to stop smoking which was higher than the national and CCG average.

The practice's performance for cervical smear uptake was 93% and this was better than the national and CCG average. In 2013/14 the number of patients with diabetes who had the blood pressure monitored was 84.38%, which was higher than the national average of 78.77%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and practice surveys. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the latest national patient survey 2014 showed that 95% of patients said that they found the receptionists at the surgery helpful. Ninety per cent of patients said the nurse they saw was good at treating them with care and concern and 84% of patients said the GP they saw was good at treating them with care and concern. Ninety seven per cent of patients said they had confidence and trust in the last GP they saw. All these results were above the Clinical Commissioning Group (CCG) average.

We spoke with 21 patients during our inspection. The majority described practice staff as caring, helpful and compassionate. Two patients commented that although they thought the receptionists and GPs were caring, they felt some receptionists could be rude occasionally. All of the patients we spoke with said they had confidence in their care and that they were treated with dignity.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and the majority were positive about the service experienced. Most patients said they felt the practice offered caring and compassionate service. Patients commented staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One patient said they had not registered with nearby practices and were happy to travel to get to St Mary's Road Surgery as they found the practice offered good, caring and compassionate treatment. One patient commented they had gone straight to the hospital as they were unable to get an appointment at the practice.

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

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 2014 GP national patient survey showed 77% of practice respondents said the GP involved them in care decisions and 91% of patients felt the GP they saw was good at giving them enough time. Ninety two per cent of patients stated the nurse they saw was good at giving them enough time and 92% patients said was good at listening to them. Both these results were above average compared to national average.

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

Staff told us that translation services were available for patients who did not have English as a first language. The practice website carried a facility to translate information into 80 different languages.

Patient/carer support to cope emotionally with care and treatment

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients registered were able to complete a form to allow the practice to share information with a carer and could specify specific details that they did not want disclosing. Carers were offered referral to an external agency for a carers assessment as a chance to discuss their needs and be offered support if appropriate.

Families who experienced bereavement were contacted where appropriate. A GP told us based on the individual

circumstances a GP would call the families if appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

The practice maintained a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We looked at minutes of these meetings and saw that they were well written and comprehensive. Patient care plans and supporting information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

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 patient's 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. GPs from the practice visited patients in local care and nursing homes and links had been built with these homes. Patients living in these homes had a named GP to support continuity of care.

An ultrasound scanner was available onsite meaning patients had greater flexibility in when they could have their ultrasound scan undertaken. Patients benefited from four fulltime GPs and a stable staff team because staff retention was generally high, which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, changes to the appointment system had been made and we witnessed now more pre-bookable and open access same day appointments were available for the patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and diabetes. Staff we spoke to informed us that they use the telephone to fill in on areas which were not covered in the appointment time. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was not equipped with automatic door but there was a bell outside

the main entrance for seeking assistance. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they had only one patient who were of "no fixed abode" and would see anyone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The surgery was open from 8:00 am to 6:30 pm Monday to Friday. The surgery was closed on bank and public holidays and it was advised to call 111 for assistance during this time. The surgery offered range of scheduled appointments to patients every weekday from 8am to 5:30pm including open access appointments from 11am to 12pm. The surgery opened for extended hours appointments one late evening (6:30pm - 7pm) and two early mornings (7:30am - 8:00am). The surgery also opened on Saturday mornings every 6 weeks, where pre-bookable appointments could be made. Extended hours were provided without any extra funding and were particularly useful to patients who worked full time.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes as and when required, by a named GP and to those patients who needed one.

Are services responsive to people's needs?

(for example, to feedback?)

The GP national patient survey 2015 information we reviewed showed patients responded very positively to questions about access to appointments. For example, 92% described their experience of making an appointment as good compared to the CCG average of 89%. Seventy one 71% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%. Eighty eight per cent said they could get through easily to the surgery by phone compared to the CCG average of 79%. Ninety five per cent said they found receptionists at this surgery helpful as compared to CCG average of 88%. Fifty five per cent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

We spoke with 21 patients on the day of our inspection. Ninety eight per cent of patients said they were positive about the care and treatment they received from the practice. Patients told us they had been listened to by both GPs and nurses and that their care and treatment met their needs. We saw staff interaction with patients was carried out with respect and compassion. Waiting areas were located close to treatment rooms.

We received further feedback from 25 comment cards from patients who visited the practice. The comments cards reviewed were generally positive. Most patients commented how they were completely satisfied with the services provided by the practice. Patients described staff as professional and caring. Two patients commented they found it difficult to get an appointment, and one patient decided to leave the practice. We looked at the appointment system and saw routine appointments with a named GP could be booked in advance. There was ample availability of advanced named GP appointments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice website and leaflet. The complaint procedure was displayed in the waiting area and blank complaint forms were available from reception. The complaint procedure had not provided further information on how to make complaint on someone's behalf and there was no information on advocacy services available for patients.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found practice kept record of all written complaints received, investigated and responded to, where possible, to the patient's satisfaction with an apology. We reviewed the response letters and witnessed that patients were not provided information about parliamentary and health service ombudsman to review their complaint if remain unhappy with resolution but this information was included in practice complaint policy.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Staff told us complaints were openly discussed to ensure all staff were able to learn and this was reflected in some of the records we reviewed.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and development business plan.

The practice had a documented business development plan in place, which had been regularly reviewed in the last two years. The business development focused on areas such as; high standard of medical care, high standards of innovation and doctor satisfaction, continue to be a learning organisation, and to relocate to new premises. The practice regularly discussed and monitored the development plan to ensure objectives were being achieved.

All the staff we spoke with knew and understood the vision and values of the practice and their responsibilities in relation to them. Staff we spoke with said they enjoyed working for the practice and that everyone was signed up to the aims and objectives.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at GP partner team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice did not always take all measures to identify, assess and manage risks. For example, the practice had not completed risk assessments in areas such as fire, legionella and infection control.

Leadership, openness and transparency

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 one of the GP partners was the lead for safeguarding. The GPs had clinical lead roles in dermatology, diabetes and COPD. The nursing team had expertise and lead roles in child immunisations, family planning and asthma. All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes the practice held regular clinical and non-clinical meetings. We reviewed various meeting minutes and saw there was clear flow of information being discussed and shared. For example, we saw in the GP business meeting minutes dated May 2014, areas of discussion included, staffing, safeguarding, significant events, PPG, and the building. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as recruitment and induction policies which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on health and safety, medical records and patient confidentiality at work. Staff we spoke with knew where to find these policies if required.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, midwives and health visitors.

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

The practice had gathered feedback from patients through comments received from the Friends and Family Test (FFT) and patient feedback collected for GP appraisal and revalidation requirements.

The practice had a patient participation group (PPG) in place, with approximately eight patients. PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. The PPG members met twice every year. The PPG published a newsletter to inform patients about recent developments within the practice.

Are services well-led?

Good 

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

PPG members we spoke with told us they felt the practice listened to the views of patients and acted upon them. The PPG members told us they were involved with choosing the waiting room furniture and the interior design for the new building. They told us the management team listened to their concerns, made improvements, and monitored these to ensure patients were happy.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt valued as part of the practice team and were encouraged to give feedback and felt listened to. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed promptly and appropriately. Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was supportive of training. For example, one member of staff told they had requested further training on the diabetes and this had been provided by the practice.

The practice had completed reviews of significant events, complaints and other incidents which included lessons learned. We saw evidence that significant events were discussed at practice meetings and the lessons learned were shared with staff to ensure the practice to ensure the practice improved outcomes for patients.

The practice was a GP training practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must comply with assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks. And assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (1) (2) (a) (b) & (h).
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person must ensure information specified in Schedule 3 is available in relation to each person employed. Regulation 19 (2) (a) & (b).