Maidstone Road Rainham Surgery

Quality Report

53a/b Maidstone Road
Rainham
Gillingham
Kent
ME8 0DP
Tel: 01634 231423
Website: None

Date of inspection visit: 4 December 2014
Date of publication: 21/05/2015

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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Maidstone Road Rainham Surgery on 4 December 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing services that are safe, effective, responsive, and well led. The practice is rated as outstanding for providing caring services. It was also good for providing services to families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable 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. Risks to patients were assessed and well managed.
- Patients' needs were assessed and their care was planned. Data showed that in the diagnosis and management of illness the patient outcomes were generally above average nationally and locally. 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 decisions about their care and treatment. Information to help patients understand the services available was easy to comprehend. Staff made special efforts to help patients who had particular needs to manage their appointments. Staff treated patients with kindness and respect, and maintained confidentiality.
- Patients said they found it easy to get through to the practice on the telephone. They were able make an appointment with a named GP and that there was continuity of care, with urgent appointments available

Summary of findings

the same day. 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.

- There was a leadership structure and staff felt supported by management. There was systematic clinical governance.

We saw some outstanding practice:

- The NHS national survey on patient satisfaction for the practice showed that patients were very satisfied with how they were treated. For example, the responses to the questions about GPs giving patients enough time, having trust in their GP and explaining tests were positive at 98%, 98% and 95% respectively.
- The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of practice respondents said the GP involved them in care decisions.
- Patients, including vulnerable people and mothers with young babies were routinely telephoned at home, on the day of their appointments, either to be asked to come in earlier, as an appointment had become available, or to be asked to delay coming in because the appointments were running late.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were mostly above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) 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 and any further training needs had been identified. There were appraisals and the personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. The practice demonstrated a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and the practice responded quickly to issues raised. There was evidence of learning from complaints.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the practice 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. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were mostly better than locally and nationally for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people. It offered home visits and rapid access to GPs and nurses for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. There were structured regular reviews to check that their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were very high for all standard childhood immunisations with the practice consistently achieving better rates than locally or nationally. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses. There were emergency processes and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

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

to ensure these were accessible, flexible and offered continuity of care. The practice offered online services, such as booking appointments, as well as a full range of health promotion and screening that reflected the needs for this patient population group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for all the patients with a learning disability. It offered longer appointments for people with a learning disability and was flexible in making appointments for them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 people experiencing poor mental health (including people with dementia). All the patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Nearly 90% of patients with dementia had received a face to face review of care during the previous 12 months.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with three patients. We received 31 completed comment cards.

All the patients were pleased with the quality of the care they had received. The themes running through the comments cards and the patient interviews were that GPs and nurses listened and gave patients enough time to express themselves. Several patients said that clinical problems had been picked up by GPs and nurses early and this had helped with their treatment. Patients said that it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 247 survey forms were sent out and 122 were returned. The main results from that survey were:

- Patients found it easy to get through to the surgery by telephone
- GPs and nurses treated them with care and concern
- Patients said that their overall experience of the practice was good

There were no areas of the survey were the results were significantly worse than the average for the locality.

Ninety five percent of patients would recommend this surgery to someone new to the area.

Outstanding practice

We saw evidence of some outstanding practice:

- The NHS national survey on patient satisfaction for the practice showed that patients were very satisfied with how they were treated. For example, the responses to the questions about GPs giving patients enough time, having trust in their GP and explaining tests were positive at 98%, 98% and 95% respectively.
- The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of practice respondents said the GP involved them in care decisions.
- Patients, including vulnerable people and mothers with young babies were routinely telephoned at home, on the day of their appointments, either to be asked to come in earlier, as an appointment had become available, or to be asked to delay coming in because the appointments were running late.

Maidstone Road Rainham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP and a practice manager.

Background to Maidstone Road Rainham Surgery

The Maidstone Road Rainham Surgery is a GP practice located in an urban area of Rainham Kent. It provides care for approximately 4600 patients. The practice has a branch surgery at Upchurch Sittingbourne. This surgery is more rural and is a dispensing surgery. The practice has a higher percentage of patients aged 65 and over than other practices nationally. The number of patients with long term medical conditions is marginally more than the national average.

There are three GP partners, two male and one female. One regular locum GP is engaged by the practice. There are three female practice nurses. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from the central surgery at

53b Maidstone Road,

Rainham,

Gillingham,

Kent,

ME8 0DP

And at

56 Oak LaneUpchurchSittingbourneKentME9 7AU

We visited both surgeries during our inspection. The practice has opted out of providing out-of-hours services to their own patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data,

Detailed findings

results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 4 December 2014. During our visit we spoke with a range of staff including; GP partners and salaried GPs, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents or near misses. For example, we looked at an incident where a patient did not get the medicine prescribed following discharge from hospital. The practice learned from the event and a different system was implemented to reduce the risk of a similar incident happening again.

We reviewed records where safety incidents had been discussed over the previous year. These showed that the practice had managed these consistently over time and was able to demonstrate of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the previous year. There was an accident book which was kept in reception and was up to date. Significant events and accidents were discussed at staff meetings and staff told us of some of the events and what had been learned. There were records which showed that the meetings had taken place but not all had been minuted. Staff, including receptionists, administrators and nursing staff, knew how to raise issues at the meetings. They said there was an open door policy and they felt confident that they could raise an issue and that they would be listened to.

We looked at the system used to manage and monitor incidents. Incident reports were completed comprehensively and timely manner and action taken as a result. For example, there was an incident where a letter had been left for a patient to collect but the patient had not been told that it was ready for collection. A new process was introduced where specific staff were tasked to follow up on such letters.

There was a process for dealing with safety alerts. These were received by the practice manager and passed to the GPs and nurses when the alerts were relevant. Staff we spoke with were able to give examples of recent alerts that were relevant to their field of practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all staff had received relevant training on safeguarding. GPs and nurses had been trained to level three and two respectively in child safeguarding. 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. There were posters about safeguarding and how to make referrals accessible to staff within the practice. There was a nurse lead for safeguarding children and adults. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. GPs told us about the safeguarding meetings they had attended and that there were currently no children within the practice on the safeguarding register.

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 or patients with learning disability. Staff were able to show us examples of how the system was used and in what circumstances they would use it.

Patients said they felt safe at the practice. The practice offered a chaperone option where a member of staff would be available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved). There were notices in the waiting area and in consultation rooms informing patients about chaperones. When chaperones were used this was recorded in the patient's notes.

Medicines management

There were processes to check medicines were within their expiry date and suitable for use. Medicines and vaccines were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure

medicines were kept at the required temperatures. Medicines storage area temperatures were regularly recorded. All the medicines we checked were within their expiry dates and there was a stock control system supported by a monthly stock audit. Expired and unwanted medicines were disposed of in line with regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received the appropriate annual training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support.

We visited the branch surgery at Oak Lane, Upchurch, Sittingbourne where the practice dispensed medicines. The practice had established a service for people to pick up their medicines at the practice's branch surgeries and had systems to monitor how these medicines were delivered and distributed. The practice had a system to assess the quality of the dispensing process. Records showed that all members of staff involved in the dispensing process had received appropriate training. The practice management regularly checked the competence of staff. The practice received regular support and audit for the local CCG prescribing advisor.

There was a comprehensive policy for repeat prescribing. The practice had a system for checking that repeat prescriptions were issued with reference to the medicine review date for each patient. Repeat prescriptions were handed into the practice, there was a repeat prescriptions box in the waiting room or patients handed them to the reception staff. They were not accepted over the telephone. The repeat prescriptions were checked by staff and were always checked by a GP before issue. If medication reviews were indicated before a repeat prescription was to be issued staff would make the appointment for this. In any cases of doubt staff referred the matter to the GP on duty. Blank prescription forms were handled in accordance with national guidance.

Cleanliness and infection control

The premises were clean and tidy and there were cleaning schedules directing which areas should be cleaned, how often and with what products. Staff cleaned the consulting and treatment rooms during the lunchtime break. Patients we spoke with said that the practice was clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy, which included procedures and protocols for staff to follow. For example, hand hygiene, clinical waste management, and personal protective equipment (PPE) use. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with PPE including a range of disposable gloves, aprons and coverings. Antibacterial gel was available in the reception area for people to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice.

We spoke with the lead for infection control. They had had training to help 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. The infection control lead had carried out audits and there had been changes, such as changes to the type of sharps disposal boxes, as a result. There was a policy for dealing with needle stick injuries and there were posters on display to assist staff were such as event to happen.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. Equipment had been tested and appeared to be in good working order. For example, records of the testing of a spirometer, an apparatus for measuring the volume of air breathed in and out, indicated that it had been checked weekly. There was regular testing of portable electrical appliances and calibration of medical equipment. There was a contract with a specialist medical maintenance company to carry this out.

Staffing and recruitment

Personnel records contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and criminal record checks through the Disclosure and Barring Service. There were records to show that the professional registration checks for staff with the National Midwifery Council or the General Medical Council had been

completed. The practice comprised a small staff team and the manager ensured that only one member of staff was on leave at any one time. The staff covered for each other's absences.

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. Records demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements. There had recently been an increase in the number of patients at the practice and extra staffing hours had been provide to deal with the extra patient records.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door was kept locked to prevent unauthorised access. The system had been tested recently when a patient had tried to force access but had been unsuccessful.

The practice computers were linked and had an emergency alarm system which, when activated, told staff in other parts of the practice that there was an emergency in a particular room.

There were regular checks of the building, the practice environment, medicines management, staffing, dealing with emergencies and equipment. Risks identified were discussed at staff meetings.

Arrangements to deal with emergencies and major incidents

All staff had up to date basic life support training, GPs and nurses every 18 months and administrative staff every 36 months. We looked at the emergency medicines and emergency equipment available. The emergency medicines were sufficient to deal with the kind of medical emergencies that could reasonably be expected to occur at a GP practice such as anaphylaxis and diabetic emergency. These had been checked regularly and were in date. The practice had medical oxygen for use in an emergency.

There was a business continuity plan to deal with a range of emergencies. 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, such as locksmiths and maintenance contractors. The practice had a branch surgery and this building was used in the continuity planning.

A fire risk assessment had been undertaken that identified actions required in order to maintain fire safety. This included fire safety training. Fire wardens had been appointed and trained. Risks associated with staffing demands were assessed and the practice was able to respond flexibly to changes in demand.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used the National Institute for Health and Care Excellence (NICE) guidance. This was incorporated into local guidelines and care pathways. There were regular reviews of patient care and treatment in line with NICE guidance. GPs from the locality met monthly, under the umbrella of the clinical commissioning group (CCG), and discussed clinical pathways. The practice offered patients ambulatory blood pressure monitoring (which involved wearing a blood pressure monitor during their normal waking hours) to confirm whether or not they have hypertension which was in accordance with NICE guidance. Patients' calls were screened by receptionists to help ensure they did not need immediate referral to a clinician.

There was a range of nurse appointments available to patients. This included chronic disease management such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). The relevant NICE guidance for COPD rehabilitation was readily available near to the area where nurses checked patients with COPD.

The GPs led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, the GPs met each day after the morning surgery to discuss complex issues or clinical decisions. These meetings were not recorded but GPs were able to evidence how these discussions had befitted individual patients and kept their own clinical practice under review.

Data showed that the practice's performance for antibiotic prescribing was comparable to similar practices. There was evidence that the practice regularly reviewed patients with long term conditions. For example, we saw that patients with COPD were seen regularly, the practice had reviewed approximately 95% of these patients over the preceding year. For patients suffering from dementia, the practice had had a face to face review of their condition in 90% of cases during the year. This compared favourably with the local and national results which were about 85% for COPD and 83% for dementia.

The practice used computerised tools to identify patients with complex needs, these tools were provided by the CCG. There was a specific member of the nursing staff, allocated to review patients recently discharged from hospital, who made follow up telephone calls and GP appointments for these patients where appropriate.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system for completing clinical audit. We looked at three clinical audits that had been completed in the previous year. All had resulted in changes to or reviews of patient's treatment. Several patients had been recalled so that their medicines could be reviewed. One audit, concerning the importance of checking how a patient's kidneys were functioning before and after treatment with a particular medication, highlighted important issues that needed to be discussed by the GPs and nurses. We asked staff about this and they were able to show us the minutes of a clinical governance meeting where this had been discussed. There was an audit of inadequate samples for cervical smears. The information for the audit was collected at the level of individual GPs and nurses so that the individuals could learn to improve their technique.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. One such audit was linked to a safety alert about a batch of medicine which was possibly not as effective as was first thought. The practice had identified the relevant patients and sent them a letter outlining what action needed to be taken.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant

Good

Are services effective?

(for example, treatment is effective)

medicines alerts when the GP was prescribing medicines. The system was also able to print out specific information for patients receiving a fresh diagnosis or change in their care.

The practice had achieved the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. These meetings involved a careful consideration of a patient's conditions, which included spiritual, where appropriate, as well physical matters.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The GPs were appraised annually and all had completed their revalidation. Revalidation is the process through which the General Medical Council are reassured as to a doctor's fitness to practice. The practice nurse was appraised by the GPs. Administrative staff were appraised annually and all had received an appraisal for the year. All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with the manager. Mandatory training such as safeguarding, basic life support and infection prevention control had been completed by all staff. The areas of training that were considered to be most important for the safety of patients and staff had therefore been completed. Staff had completed fire safety training.

Practice nurses performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, training had been delivered on the administration of vaccines, managing patients with learning disability and complaints. Those with extended roles such as caring for patients with COPD, dementia and diabetes had had the appropriate training.

Working with colleagues and other services

The practice worked with other professionals such as district nurses, social services, GPs and other specialists. For example, there had been regular multidisciplinary meetings with the palliative care service. GPs attended monthly meetings of the CCG where initiatives, such as that involving surrounding practices and the community trust to develop integrated primary care pathways, to benefit patients moving from or between services, were developed.

The practice had protocols and systems for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. For example, the practice used "choose and book" a national electronic referral service. GPs discussed the referral and choice of hospital with the patient. Medical secretaries made the booking on the "choose and book" system and sent a letter to the patient. The patient then confirmed the appointment with the designated hospital. The practice referred minor surgery patients to other local GP practices.

The practice worked with other service providers to meet patients' needs and manage their care. Blood results, x-ray results, letters from the local hospital including discharge summaries and information from out of hours providers were received through a of variety means. These were scanned into the patients' notes and allocated to the GPs to action. All staff we spoke with understood their roles in the system and usually it worked well. There was no significant backlog of results awaiting action.

The practice was commissioned for an enhanced service aimed at preventing unplanned admission to hospital and had a process 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 had allocated a specific member of the nursing team to manage this service which was working well.

Information sharing

The practice had systems to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on how to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Information from the out of hours service (OOH) was received directly into the practice's electronic record system and the practice used their system to alert the OOH services of the details of patients receiving end of life care at home.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how

Good

Are services effective?

(for example, treatment is effective)

that consent should be recorded. Consent was specifically recorded for any invasive procedures. Staff we spoke with understood the consent and decision-making requirements of legislation and guidance.

Staff had received training in the provisions of the Mental Capacity Act 2005. GPs and nurses had an informed approach about capacity under the Act. For example, when GP was asked for an opinion about a person's mental capacity concerning a particular aspect of their care, they decided, having looked at all the information available, that there insufficient material to make a judgement. They therefore consulted with other health professionals involved in the individual's care.

Health promotion and prevention

All new patients were given a health questionnaire and offered a health check with a nurse. We looked at anonymised records of new patient assessments and saw that they were thorough. Those on repeat medications were referred to the appropriate nurse in the first instance and to a GP if necessary.

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 of all patients with a mental health problem and all of them were offered an annual physical health check. All these patients had a care plan documented in their patient record over the last 12 months.

During 2013 the practice had identified the smoking status of 526 patients over the age of 15 and actively offered nurse-led smoking cessation clinics to 525 of them. This placed the practice in the top 5% when compared with practices locally and nationally. The practice's performance for cervical smear uptake was 86%, this placed the practice in the top 20% when compared with practices locally and nationally.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was in line with the average nationally, for the previous two years the practice had achieved 100 % immunisation against national averages ranging from 92 to 96 %. For influenza vaccinations for patients over 65 years and for patients under 65 whose condition meant that they were at in increased risk if they caught influenza the practice's performance better than the national average.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The NHS national survey on patient satisfaction for the practice showed that patients were very satisfied with how they were treated. For example, the responses to the questions about GPs giving patients enough time, having trust in their GP and explaining tests were positive at 98%, 98% and 95% respectively. This compares with 68%, 72% and 76% respectively for the clinical commissioning group (CCG) average. There were very few areas where the practice dipped below the average for the CCG and this was by a very small margin. There were five comments on the NHS Choices website, where patients leave reviews about their experiences. Only three of these concerned care and treatment and were wholly positive about the practice.

Patients completed 31 comment cards to tell us what they thought about the practice which were all positive. The themes running through them were that GPs and nurses listened and gave patients enough time to express themselves. Several patients said that clinical problems had been picked up by GPs and nurses early and this had helped their treatment. We also spoke with three patients on the day of our inspection. Two of these were mothers with young babies, both of them told us that reception staff were very thoughtful. For example, both said there had been times when they had been telephoned at home, on the day of their appointments, either to be asked to come in earlier, as an appointment had become available, or to be asked to delay coming in because the appointments were running late. The reception staff told them that they thought it unfair to ask mothers with sick children to wait in the reception area if this could be avoided. Reception staff we spoke with said that they did this regularly for mothers with babies and for other patients, such as those with long term conditions, vulnerable patients or those with mental health problems, who had particular needs. This evidence was support by the NHS patient survey where 97% found the receptionists helpful as opposed to 85% for the CCG.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. This was a fairly small practice and staff knew the patients well. The reception area was separated from the waiting room so patients could not be heard by those in the waiting area. Reception staff we spoke with were alert to maintaining confidentiality and there were protocols to follow when they received telephone calls from other agencies asking for information. There was a private area where patients could talk to staff if they wished. There were notices in reception, and in consulting rooms, informing patients about the chaperoning policy.

All the patients we spoke with, and comment cards confirmed that staff at the practice treated patients with respect and were polite. Patients said staff considered their privacy and dignity. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. All the consulting rooms had substantial doors and it was not possible to overhear what was being said in them. The rooms were all fitted with window blinds and consulting couch curtains and patients said that the doctors and nurses closed them when this was necessary.

There was a 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 and gave examples of where the practice had supported staff and other patients by exercising the policy.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of practice respondents said the GP involved them in care decisions, as opposed to 82% nationwide.

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 supported the theme that GPs and nurses gave patients enough time.

There were translation services available for patients who did not have English as a first language, though staff said that they rarely had to use them. The practice used a

signing interpreter for deaf patients. The reception staff knew these patients and made appointments that were convenient, both in terms of time of day and of duration, so that the needs of these patients could be met.

Patient/carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could get access to services such as those related to specific disabilities. Patients we spoke with during the inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

The practice actively worked to identify patients who were acting as carers for other people, whether those people were registered with the practice or not. There were notices in the waiting room asking people who were carers to come forward and be registered. The practice used their computer system to "flag" individuals who were carers or who were cared for so that they could take this into account when making appointments or providing care. Notices and leaflets in the waiting room also told people how to access support groups and organisations. We looked at this information and it was comprehensive. Several comment cards remarked on the amount of useful information that was available in the practice waiting room.

When families had suffered bereavement a note was made on the receptionists' notice board, not visible to patients, so that all the staff were aware. The GP responsible for the care, or another GP in that person's absence, telephoned the family to offer support, an appointment if required and to signpost the family to other services that could support them in bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood. The practice was able to respond flexibly. For example, there had been an unexpected increase in the number of patients on the practice list and the practice had introduced systems to deal with this.

We heard staff making appointments. They were pleasant and respectful to the patients. They tried to accommodate the times that the patients asked for however, when they could not they talked with the patients to identify other suitable times. Patients had the choice of male or female GP. There were longer appointments available to patients who needed them. The computer system flagged those who had already been identified as needing longer appointments. Receptionists told us they would book longer appointments if so requested.

The practice did not have a patient participation group. However, it had received comments from patients, either through the suggestion boxes or directly to the practice manager. As a result of this the practice had changed the type of reading matter that was available to patients in the waiting room.

Tackling inequity and promoting equality

Disabled patients could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was a toilet with access for the disabled as well as mother and baby changing facilities. Staff told us that patients who were homeless could be registered as temporary patients using the practice address but that there had been no call for this recently.

All patients who had a diagnosis of dementia were flagged on the practice's computer system. When staff accessed these records a message came up on the screen informing them of the diagnosis. This helped ensure that all staff were informed and aware so that they could provide the relevant support to patients.

Access to the service

The practice was open surgery hours 8.30am – 12.30pm and 3pm – 6 pm Monday to Friday. There was an evening surgery once weekly. This was particularly useful for patients with work commitments. There were seven "emergency appointments" each day. If these filled up then the reception staff would inform the GPs who triaged the requests to determine which needed immediate attention. If necessary the surgery would overrun until all the patients, whom it was necessary to see, were seen. The practice provided a telephone consultation service for those patients who were not able to attend the practice.

The GPs carried out home visits if patients were housebound or too ill to visit the practice. There were appointments available outside of school hours. Children of school age were given appointments on the day they rang if requested. Comprehensive information was available to patients about how to make appointments. This included how to arrange urgent appointments and home visits and how to book appointments through the internet. There were also arrangements to help ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Details of how patients could access services outside of opening times were displayed on the front of the building.

Longer appointments were available for people who needed them. This also included appointments with a named GP or nurse. GPs made home visits to the three local care homes when they were required. Nurses called on housebound patients to undertake checks. For example, for patients with long tern conditions that would normally have been seen at the practice clinics. Patients were generally satisfied with the appointments system. They said they could see a doctor on the same day if they needed to. We heard the reception staff making appointments that afternoon for patients who called during the morning. Patients' comment cards said they had received emergency appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system for handling concerns and complaints. The practice manager was designated to handle all complaints in the first instance. Information was

Good

Are services responsive to people's needs?

(for example, to feedback?)

available to help patients understand the complaints system. There were posters and leaflets clearly displayed in the practice which explained the complaints system. 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 said that they had ever needed to make a complaint.

We looked at three complaints received in the last 12 months and found in each case the complainant had been kept informed by letter, there was a timely investigation and where the practice was at fault they apologised. The practice reviewed complaints annually to detect themes or trends. The report for the last review demonstrated that no themes had been identified. However, lessons learned from individual complaints had been acted on. Complaints were discussed in the practice meetings so that all staff could learn from the issues raised.

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. Details of the vision and practice values were part of the practice's statement of purpose. Staff we spoke with understood the values of the statement of purpose. For example, trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. They told us they felt well led and described a practice that was open and transparent. The GPs and the manager said that they advocated an "open door" policy and all staff told us that the GPs and practice manager were very approachable.

Governance arrangements

The practice had policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice. The policies we looked at were in date and staff had access to all policies through a computerised system. 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 GP partner leads for different areas such as finance and Quality and Outcomes Framework (QOF). All the members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing in line with or better than the national standards. We saw that QOF data was regularly discussed at practice meetings and staff undertook actions to maintain or improve outcomes.

The practice had a programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, there had been audit of patients who were prescribed certain anti-depressant medicines. This had shown that the practice was monitoring critical bodily functions, known to be affected by the medicines, of those patients. The audit had been discussed at a clinical governance meeting so that all the GPs and nurses understood why the monitoring was so important.

The practice had arrangements for identifying, recording and managing risks. There were plans to cope with interruptions to services at the practice as well as the risks posed by fire, loss of one of the practice's buildings, inclement weather and staff illness.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern and GPs supported this. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. The practice manager was responsible for human resource policies and procedures. We viewed a number of policies that supported staff. For example, disciplinary procedures, induction policy and management of sickness. There was a staff handbook which provided guidance on equality, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice did not have a patient participation group (PPG). It had tried to generate interest in a group but had not been successful. The practice had suggestions and comments boxes which were kept at both receptions. The practice took into account the views and comments of patients. For example, the practice had changed the reading material that was available to patients as a result of one such suggestion. The practice had introduced the NHS friends and family test, this asks patients if they would recommend the practice to their friends and family. Patients also have the opportunity to explain why they have given their answer, by completing follow-up questions. It had been too soon to draw any meaningful conclusions from this survey.

The practice had gathered feedback from staff through meetings and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were involved in the running of the practice and if they made suggestions for improvement these were listened to and usually acted upon. For example, the vaccines audit system had been changed as a result of suggestions made by staff. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They said the nursing staff also worked at other practices and as such brought fresh ideas into the practice. There were regular staff appraisals which staff valued and said provided them with an opportunity to discuss their performance and any training needs that they might have. Training over the previous year, across various staff members, had included dementia, respiratory nurse competence, infection control, equality and diversity and skin care in the elderly.