Arden Medical Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

The Arden Medical Centre is a small, town-centre general practice serving around 3,000 patients in the Stratford-upon-Avon area. The practice serves the local general community and provides a particular service to temporary patients visiting or working in the area, to teenagers and young people and to people who could not access services due to a history of violence.

We visited the practice on 20 May 2014 and spoke with the doctors and other staff and with patients. We also looked at procedures and systems used and considered whether the practice was safe, effective, caring, responsive to people's needs and well-led.

The Arden Medical Centre was safe. There were appropriate safeguarding procedures and an open and transparent culture among staff. Medicines were managed safely, the practice was clean and hygienic and there were arrangements in place to respond to emergencies.

The practice was effective and had procedures in place that ensured care and treatment was delivered in line with appropriate standards, except that in a very few cases people with diabetes were not provided with appropriate information. The practice measured its effectiveness through clinical audit. Staff were trained to work effectively and there were good links with other providers in the area.

The practice was caring, where patients were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and compassion offered by the staff. The GPs provided personal intervention in people's end of life care.

The practice was responsive to people's needs and met the needs of specific patient groups within its local population such as temporary patients, patients with a history of violence and teenagers and young adults. The practice had an accessible appointments system and was also accessible to people with limited mobility or to people whose first language was not English.

The practice was well led. There was strong and visible leadership with a good philosophy of care that was shared by all staff. There were effective governance procedures in place and a system of using information from patients and from records to monitor the effectiveness of the practice. There was an active patient representation group in place.

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 Arden Medical Centre was safe. There were effective arrangements in place for reporting safety incidents and an open and transparent culture that encouraged learning whenever things went wrong. There were robust safeguarding procedures in place to protect children and vulnerable adults.

Medicines, including emergency medicines and vaccines, were handled, stored and monitored properly to ensure they were safe to use. Staff were appropriately vetted for their role and they had the requisite skills, including basic life support skills, to ensure they could care for patients safely.

The practice staff understood recognised guidance on infection prevention and control and the location was regularly cleaned. The practice also had arrangements in place to ensure risks to people's safety was identified and controlled. There were also plans in place to ensure the practice could still operate in the event of a major incident.

Are services effective?

The practice was effective. There were procedures in place to ensure that care and treatment was delivered in line with best practice standards and guidelines, although the approach was inconsistent in a very small number of cases in relation to the diagnosis and recording of diabetes.

We saw a completed clinical audit cycle. An audit cycle is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented to assess their effectiveness. The cycle we looked at assessed the improvements made in the way that patients with a history of diabetes in pregnancy were monitored and treated.

There was an effective system in place to manage the health reviews of patients with long term conditions and there were effective links with other health and social care providers. This was particularly the case in relation to people who were receiving care at the end of their lives.

We found that staff had access to the training they needed to carry out their roles effectively and were supported through annual appraisals.

Summary of findings

Are services caring?

The practice was caring. We found that people were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and compassion offered by the staff. The attitudes and behaviour of the staff reflected the practice charter.

Patients were involved in planning their care and treatment except that in some cases people were not initially provided with information about their diabetes where their blood test results were borderline.

Patients receiving end of life care were provided with personal care by the GPs at the practice.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice met the needs of specific patient groups within its local population such as temporary patients, patients with a history of violence and teenagers and young adults. The practice had limited its patient list due to the size of the building and its related capacity.

The practice had accessible appointment and prescription arrangements and was accessible to people with limited mobility or whose first language was not English.

There was a clear complaints policy and a whistleblowing policy, both of which had been used effectively.

Are services well-led?

The practice was well led. There was strong and visible leadership with a good philosophy of care that was shared by all staff.

There were effective governance structures which included regular communication within and external to the practice. However, not all of the practice and clinical meetings were recorded which meant key decisions could not easily be audited.

The practice made use of information acquired directly from patients and information held electronically to manage and improve the provision of services.

There was an active patient participation group which was used effectively by the practice, and feedback from patients was used to help the practice to learn and improve. This practice had called the group the patient representation group (PRG).

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 provided a personal, caring service for people receiving palliative care. Flexible appointments were available for seasonal flu jabs. Older people who had moved in to care home accommodation retained their GP if this was their choice

People with long-term conditions

The practice supported patients and their carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care.

The review dates of patients with some long term conditions such as heart disease, chronic breathing problems and stroke were monitored to ensure their health needs were regularly considered.

In a very small number of cases, patients with diabetes were not routinely informed of their diagnosis.

Mothers, babies, children and young people

Women with a history of diabetes in pregnancy were given an additional opportunity for a further blood test and further treatment and advice where necessary.

The practice held childhood immunisation clinics. The practice also held twice weekly walk-in teenage and young adult health clinics.

The working-age population and those recently retired

People who were looking after others were supported through a carers assessment with a referral onwards to other services if required

The adult health screening programme for people aged between 40 and 75 was due to commence in the weeks following our inspection.

People in vulnerable circumstances who may have poor access to primary care

People could gain access to written information online in different language formats if their first language was not English.

The practice operated a service specifically for those patients who could not get access to primary care elsewhere due to a history of violence.

Summary of findings

People from travelling communities and those working in the tourist industry were able to register as temporary patients on a walk-in basis. Home visits and telephone consultations were available for people who could not get to the surgery. There was also an access ramp for people with restricted mobility.	
People experiencing poor mental health The practice was about to begin an arrangement with the mental health service to improve patients' access to psychological therapy.	

Summary of findings

What people who use the service say

The Arden Medical Centre had carried out its own survey at the end of 2013, which showed that almost all patients were very satisfied with their care and treatment. These findings were reflected in the national GP NHS patient survey carried out in 2013. 100% of patients surveyed said they would recommend the practice to others whilst the overall patient rating was 94%, significantly above the national average of 84%.

Patients we spoke with on the day of our inspection told us they were very happy with the standards of care received at the practice. Similarly, we received a high number of comment cards on the day of our inspection. All the comments were positive and told us that the practice was caring and compassionate.

Areas for improvement

Action the service COULD take to improve

The practice did not always make formal records of practice or clinical meetings.

Good practice

Our inspection team highlighted the following areas of good practice:

- Arrangements were made to ensure that patients from the area with a history of violence could access primary medical care.
- Findings from a clinical audit in relation to the monitoring of women with a history of diabetes in pregnancy were shared with a peer group of GPs from other local practices in order to improve the approach locally.

Arden Medical CentreArden Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

We carried out our inspection of Arden Medical Centre with a team that was comprised of two inspectors and a GP specialist adviser.

Background to Arden Medical Centre

Arden Medical Centre, in the South Warwickshire Clinical Commissioning Group (CCG) area, provides a range of primary medical services to around 3,000 patients from a surgery in an older, converted building near the centre of Stratford-upon-Avon.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward and at the same time as a group of other practices in this CCG area. This practice had not been inspected before and that was why we included them in this group of inspections.

How we carried out this inspection

We conduct our inspections of primary medical services, such as Arden Medical Centre, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 20 May 2014. During our visit we spoke with the three doctors, the practice manager, the practice nurse and a receptionist. We also spoke with patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed CQC comment cards completed by patients using the service on that day where they shared their views and experiences.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Are services safe?

Summary of findings

The Arden Medical Centre was safe. There were effective arrangements in place for reporting safety incidents and an open and transparent culture that encouraged learning whenever things went wrong. There were robust safeguarding procedures in place to protect children and vulnerable adults.

Medicines, including emergency medicines and vaccines, were handled, stored and monitored properly to ensure they were safe to use. Staff were appropriately vetted for their role and they had the requisite skills, including basic life support skills, to ensure they could care for patients safely.

The practice staff understood recognised guidance on infection prevention and control and the location was regularly cleaned. The practice also had arrangements in place to ensure risks to people's safety was identified and controlled. There were also plans in place to ensure the practice could still operate in the event of a major incident.

Our findings

Safe Patient Care

We found that Arden Medical Centre had an open and transparent culture amongst all its staff about keeping people safe. This included an understanding of the processes for reporting incidents that affected people's safety and instances of potential abuse. We saw that there was a process for escalating complaints and other incidents, known as significant events, to the practice partners so that they could be discussed during monthly senior staff meetings.

Whilst these incidents had been very rare, we saw examples of when this had occurred and that staff had been alerted to the risks. We reviewed a particular significant event which had initially been identified by a staff member and escalated through the practice manager to the practice partners. This incident had been investigated and dealt with in a robust manner. As a result, clear instructions had been issued to non-clinical staff to ensure they did not provide clinical advice to patients.

Learning from Incidents

We also saw that a clinical audit had been carried out by one of the GPs about their approach to monitoring and treating patients with a history of diabetes in pregnancy. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented to assess their effectiveness. The initial audit findings had identified that blood glucose levels of those patients that were affected had not been monitored after pregnancy at the time intervals recommended by national guidelines. The awareness of the importance of this issue was raised amongst all of the staff team at a staff meeting. A new robust system of patient recall was implemented using the practice's computer system. Patients who had been affected were recalled and blood glucose tests were carried out. This ensured there were opportunities to diagnose on-going diabetes and to provide appropriate diet and lifestyle advice that had previously been missed.

The audit also identified the need for some further research to be carried out. This was in relation to the observance, by the local NHS hospital trust, of the national guidelines on

testing patients' glucose levels after pregnancy. As a result, the findings and rationale of this audit had also been shared externally with a peer group of GPs from other practices in the area in order to consider that further work.

This showed that the practice used the findings from the analysis of incidents or events to promote learning both within the practice and the local medical community.

Safeguarding

The practice had procedures in place for reporting potential abuse and one of the doctors was designated as the practice lead for safeguarding. All staff had received training in protecting children and vulnerable adults that supported the practice safeguarding policy. Further staff training to a more advanced level was also scheduled for the month following our inspection visit.

Staff were confident in their ability to identify and respond to abuse appropriately. We discussed an incident with the practice manager where concerns had been identified and properly reported using the local authority's safeguarding procedures. We found that the practice's safeguarding procedures were effective.

Staff were aware of the practice confidentiality policy, including 'clear-desk' instructions, and the need to keep patients' information secure. We saw that the computer screens in the reception area were kept out of general view and there were no handwritten notes or paper records in use. This ensured that information about patients was protected.

Medicines Management

There were suitable arrangements in place to ensure that all medicines were handled, stored and administered safely. We saw that the cold chain was maintained for the storage of temperature sensitive vaccines. Checks were regularly made on the temperature of the fridge to ensure it remained within acceptable limits and that the vaccines were therefore safe to use. Accurate stock records of the vaccines were kept, which included batch numbers and expiry dates. This ensured that each vaccine could be tracked and attributed to the records of each particular patient it was given to.

The practice did not dispense medicines directly to patients but a small quantity was kept for use in the surgery, including emergency medicines. All medicines were stored appropriately and records were maintained of all stock movement, their batch numbers and their expiry dates which ensured they were safe to use. The practice carried a very small quantity of one type of controlled drug used as a pain reliever which was securely stored separately to the other medicines, along with its own log book.

Cleanliness and Infection Control

There were effective arrangements in place to ensure that patients and staff were protected from the risks of acquiring health care associated infections and that the relevant guidance and codes of practice on infection control were followed. The practice was cleaned twice weekly according to a schedule and we saw that all areas appeared clean and uncluttered. There were also appropriate arrangements for the management, storage and collection of clinical waste.

Staffing and Recruitment

We found that the practice took proper steps to ensure that staff employed there were of good character. For example, we saw that Criminal Records Bureau or Disclosure and Barring Service checks had been carried out in respect of those members of staff whose role required it. The need for such checks on staff carrying out other roles, such as the reception staff, was properly considered through a documented risk assessment. Each staff member's previous character, skills, qualifications and experience was considered at the point they were employed through a robust interview and referencing process. This meant that the provider could be assured the staff they employed did not present a risk to patients.

We noted that the practice had an additional member of staff who worked according to flexible arrangements. This enabled the practice to respond to changing demands such as during the winter period when the practice was busier.

Dealing with Emergencies

The practice had a business continuity plan. This enabled the provider to relocate the surgery in the event of a major incident by making use of the arrangements in place with the peer group of practices in the area and the home of one of the practice partners. This plan, and the practice risk assessments, were subject to an annual review that was scheduled as a diary event. This meant that health and safety risks and their control measures were regularly monitored.

Are services safe?

Monitoring Safety and Responding to Risk

We spoke with the practice manager who talked us through the documented practice risk assessments. We saw that risks to people's safety had been identified and steps taken to control them. Those steps included time-bound actions taken by a named member of staff. For example, the practice manager had been responsible for changing the arrangements for storing consumable products, such as couch rolls, in order to eliminate the risk of staff falling down stairs whilst carrying them. We also noted that risks to patients from the wheelchair and pushchair access ramp had been reduced by cutting back overgrown bushes and removing loose concrete.

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received training in basic life support and in the use of an automated external defibrillator (AED). The AED and emergency oxygen were readily available and checked weekly. The practice carried a small stock of medicines for use in the event of a medical emergency. We saw that emergency medicines were kept in an accessible box with information about their use. These were checked weekly to ensure they were within their expiry dates.

We saw that the practice manager carried out monthly searches of the records system to identify whether patients had attended the practice for treatment or medication reviews or for scheduled vaccinations. This ensured that patients, particularly those with long term conditions, were not at risk of missing those reviews. We have reported on this in more detail in the section on 'Effective' below.

The practice manager also told us that they had begun to use a risk monitoring method known as 'risk stratification', a process designed to identify which patients were most at risk of re-hospitalisation. We were informed that this had identified two patients who were at risk and that risk management plans had been drawn up for those patients.

Equipment

We found that patients were protected from the risks arising from the use of unsafe equipment because there were arrangements for checking such equipment. We saw test and calibration records of, for example, the AED, the vaccination fridge, ultrasound equipment and thermometers that showed they had been checked regularly and were working correctly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. There were procedures in place to ensure that care and treatment was delivered in line with best practice standards and guidelines, although the approach was inconsistent in a very small number of cases in relation to the diagnosis and recording of diabetes.

We saw a completed clinical audit cycle. An audit cycle is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented to assess their effectiveness. The cycle we looked at assessed the improvements made in the way that patients with a history of diabetes in pregnancy were monitored and treated.

There was an effective system in place to manage the health reviews of patients with long term conditions and there were effective links with other health and social care providers. This was particularly the case in relation to people who were receiving care at the end of their lives.

We found that staff had access to the training they needed to carry out their roles effectively and were supported through annual appraisals.

Our findings

Promoting Best Practice

The GPs we spoke with told us about their clinical meetings that occurred two to three times every month. At these meetings the doctors discussed changes to guidance and best practice issued by, for example, the National Institute for Health and Care Excellence (NICE) for the NHS. This ensured that the medical staff were aware of such developments that affected the way they assessed and delivered care and treatment. For example, as we have reported in the section on 'Safe' above, the practice had measured their application of the NICE guidance for monitoring the blood glucose levels of women who had been at risk of diabetes during pregnancy.

We found, though, that the practice's approach to promoting best practice according to established guidance was inconsistent. In one instance we saw that the NICE quality standards for the treatment of patients receiving end of life care and their families were met. In particular, the standards for those patients who were nearing the end of their lives were exceeded due to the direct, personal involvement of the GPs at that time. We have noted this in the section on 'Caring' below as an example of good practice.

However, one of the GPs told us that a small number of patients, who had blood results supporting a diagnosis of diabetes, albeit with a borderline result, were not routinely informed of the diagnosis. The doctor explained that the dietary and lifestyle advice and annual follow up given to those patients at this stage would be the same whether or not they had been informed of their condition. Information would only be withheld for those few patients due to psychological reasons if it was considered that the patient would not benefit from knowing the diagnosis and provided they were monitored and reviewed regularly. A formal diagnosis of diabetes would be provided to all other patients. Whilst the effect of withholding this information meant that some patients were not initially given the opportunity to be involved in their treatment planning or to provide informed consent, this was, nonetheless, a further example of the patient centred approach taken at this practice.

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

We found that the practice was making use of reference data collected by the NHS in order to gain an insight into the effectiveness of the practice. This information was taken from the Quality Outcomes Framework (QOF) system; the national data management tool generated from patients' records that provides performance information about primary medical services. We noted, for example, that the practice was lower than the established reference range for the prevalence of a number of conditions such as depression, chronic kidney disease, heart failure and diabetes for the financial year 2012 to 2013. The data for diabetes in particular showed a significantly lower prevalence than expected when compared with other practices in the area.

We discussed this with one of the GPs who explained that their approach to sometimes withholding information from patients about their diagnosis of diabetes where the test results were borderline also occurred for some patients with a diagnosis of chronic kidney disease. They acknowledged it was likely that the data reflected their differential approach because this affected the way that such conditions were recorded on the QOF system. We saw that the clinical team were investigating this link by means of an ongoing action plan, and that this involved a scheduled meeting with the diabetes lead for the Clinical Commissioning Group (CCG) to consider the issue.

Furthermore, the practice manager had started a programme of monthly searches and a review of information from the QOF system to see where improvements could be made. We saw that this action also enabled the provider to identify which particular patients needed to be discussed further.

We noted that the practice performance in the QOF reports for 2012 – 2013 showed a total of 98.8% of QOF points achieved. This was above the average for all practices in England.

Staffing

The practice employed staff who were appropriately skilled and qualified for their role and supported them with an effective training regime. This included an induction process where new employees were mentored through a three-month probationary period. We saw that training was monitored by the practice manager to ensure that staff received updates on key aspects of their role according to a schedule.

We saw that arrangements were in place to ensure that all clinical staff were revalidated in accordance with their professional registration by means of continuing professional development. For example, the practice nurse was supported to receive annual updates in key aspects of their role, such as anaphylaxis and immunisation, by means of study days that were funded by the practice.

An effective appraisal process was being implemented. We spoke with the practice nurse who shared with us the outcome of their appraisal. We saw that they had already received regular annual appraisals from one of the GPs where learning opportunities were identified and discussed and arrangements put into place to meet learning needs. This process was being implemented for all other members of staff. Its effectiveness had yet to be measured as the first scheduled appraisals were due to take place within weeks of our inspection. We also saw evidence that there was an effective system in place for identifying and managing performance of staff that fell short of expectations.

This showed that patients received care and treatment from a skilled, motivated and effectively supervised staff team.

Health Promotion and Ill-Health Prevention

We saw that the practice had a range of printed information available in the reception area relating to the promotion of good health and the prevention of ill-health, such as information about smoking, diet and allergies. This meant that patients had access to enough information to help them to understand risks to their health.

We saw that people who were caring for others were given information in a 'carer's pack' about local services. Those patients who were identified as carers were asked to complete a questionnaire and were given a specific assessment by one of the GPs. If necessary, carers were referred onwards to relevant local social care or health agencies and this ensured that carers and those they were caring for received appropriate support.

We saw that the care patients were receiving at the end of their lives was monitored by means of a multi-disciplinary team (MDT) meeting involving the doctors, the practice nurse, the community nursing team and the MacMillan

Are services effective?

(for example, treatment is effective)

service. Each person receiving such palliative care had an end of life care plan. The purpose of the monthly team meetings was to discuss each person and to make alterations to their care plan based on their evolving needs. The MDT meeting also discussed each person's death after they had passed away to review whether their care plan had been effective. We looked at the anonymised records of a number of these meetings and saw evidence of how this had worked over time. This ensured that patients received care that met their particular needs and that their preferences about their death were fulfilled.

We noted that the practice manager used the computerised records system to monitor the review dates of those patients with long term conditions, such as diabetes, heart disease, chronic breathing problems, dementia and stroke. Review dates were entered onto the system in accordance with timescales identified during their consultation. This enabled the practice to recall those patients for a review of their health at the most appropriate time as determined by their own needs. It also ensured that those who chose not to attend could be identified and followed up where necessary.

The practice health care assistant had just completed training in health screening. We saw that the adult health screening programme was scheduled to start within weeks following our inspection for patients aged between 40 and 75 without any diagnosed long term conditions. The practice had already identified and prioritised their list of patients whom they would be offering these checks to.

Working with other services

We noted that the practice had been discussing an arrangement with the mental health service for the use of one of the consulting rooms at the practice for an initiative known as Improving Access to Psychological Therapy (IAPT). This would enable local people who were suffering from anxiety or depression, not just the patients registered at this practice, to gain access to the particular services offered by IAPT.

The practice operated an email notification system with the out-of-hours service. This enabled the efficient exchange of information about patients using the out-of-hours services and ensured any follow-up action could be taken by the practice if required. We also saw that the practice shared key information with the out-of-hours service and the ambulance service about patients nearing the end of their lives, particularly information in relation to decisions that had been made about resuscitation in a medical emergency. This ensured that patients' preferences about their death could be fulfilled.

We noted that there were patient information folders in both waiting areas. These folders contained comprehensive, up to date information and contact details for local health and care services, such as mental health services, drug and alcohol services and the local authority safeguarding team.

Are services caring?

Summary of findings

The practice was caring. We found that people were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and compassion offered by the staff. The attitudes and behaviour of the staff reflected the practice charter.

Patients were involved in planning their care and treatment.

Patients receiving end of life care were provided with personal care by the GPs at the practice.

Our findings

Respect, Dignity, Compassion and Empathy

All of the people we spoke with during our inspection, including the members of the patient participation group we spoke with in advance of our visit, told us that the doctors and staff were caring and compassionate. Patients said they were listened to and that their views and wishes were respected.

We received a high number of comment cards that were completed by patients who were visiting the practice on the day of our inspection. Without exception, the comment cards reported positive experiences of patients in relation to their treatment. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We saw that the practice displayed a copy of their patient charter prominently in reception, which set out what patients could expect from staff. For instance, patients could expect to be treated with courtesy, dignity and respect at all times and could have access to a chaperone if required for sensitive or intimate consultations. During the course of our inspection we observed a number of interactions between staff and patients where people were consistently treated with respect, compassion and dignity, both in person and on the telephone.

Whilst we saw a range of information available in leaflet form in the reception area about people's health, the literature was all in English. However, we noted that patients could gain access to written information online in different language formats if their first language was not English.

There was also a sign offering patients a more confidential environment if they wished to have a private conversation with staff away from others in the reception area.

Involvement in decisions and consent

We found that patients were mostly involved in decisions about their treatment. Patients reported they had the opportunity to ask questions and felt their views were listened to.

We found that the practice made appropriate, caring arrangements for patients receiving end of life care so that their preferences at the time of their death could be met. As patients approached the last few days of their lives, the

Are services caring?

doctors provided their personal contact details to the patients' families and supporters so that they could call them direct whenever they needed to. This would be, for instance, if the person passed away or if someone required pain relief out of normal surgery hours. Furthermore, the information supplied to the out of hours service and the ambulance service, including patients' wishes and decisions made about resuscitation, meant that their preferences about their death could be fulfilled. We learned that, within the last year, 17 out of 18 patients who had died had been able to do so in their own homes according to their own wishes.

We noted that patients' relatives were also supported once they were bereaved by way of a personal visit from the doctor to determine whether they needed any additional emotional or practical support.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to people's needs. The practice met the needs of specific patient groups within its local population such as temporary patients, patients with a history of violence and teenagers and young adults. The practice had limited its patient list due to the size of the building and its related capacity.

The practice had accessible appointment and prescription arrangements. The practice was accessible to people with limited mobility and to people whose first language was not English.

There was a clear complaints policy and a whistleblowing policy, both of which had been used effectively.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it serves and acts on these to design services. For example, we learned that the practice had become a walk-in centre for temporary patients who were visitors to the town and who would not ordinarily have permanent access to primary medical care. These patients included people from travelling communities, those working in the local tourist industry and members of theatre companies. We saw that there had been over 60 such new temporary patients registered with the practice in the three months leading up to our inspection.

The practice also operated a twice-weekly teenage and young adult health clinic at times that were intended to fit around school hours. This was a service offered to all local teenagers; both those patients who were registered at the practice and those who were not. This meant that young people who wished a consultation away from their usual practice could have access to a confidential service.

We found that the practice engaged with the local authorities and the commissioners of primary care to put arrangements in place to see those patients who could not access services due to their history of violence. Such patients were routinely seen as part of pre-planned appointments at the local police station by one of the GPs.

We noted that arrangements were also in place on the computer system to alert the staff about patients' faith or other needs that would affect their decisions about their health care. This meant that the doctors were aware of such needs in advance of their consultation and saved the patients from being asked about their beliefs on every occasion.

The practice also engaged with local community nursing teams and the MacMillan service to ensure that patients' end of life care was monitored and adjusted to reflect changes in their needs over time.

The practice also ran a range of discrete clinics and services such as weekly diabetic and antenatal clinics, a weekly phlebotomy service and immunisation and seasonal flu vaccine clinics. An independent acupuncturist also operated an occasional clinic from a surgery at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

The practice was not commissioned to provide a dedicated GP service, known as a local enhanced service, to any particular care home. However, some of the patients registered with the practice who moved into such accommodation chose to retain their registration with the GP and this choice was supported by the practice.

We noted, however, that the practice had posted an instruction behind the reception area that gave staff guidance on registering patients. The guidance stated which patients could be registered automatically but that patients that were already registered with a GP in Stratford ought not to be registered. There was no evidence that the practice had consulted other local practices about this. We discussed this with the practice manager and one of the GPs who explained that they felt it important that they were not seen as encouraging patients away from other practices. They also explained that the size of the practice premises and staff team meant that the services they provided might not be as viable or effective if the patient list grew by an appreciable amount. Whilst we acknowledge that there are good reasons for limiting the size of the patient list, the practical effect of this is to limit patients in the area as to their choice of primary medical care provider.

Access to the service

We found that the practice was accessible. Appointments could be made in person, online or on the telephone. Patients who needed to see a doctor that day could do so at the end of the normal appointment list. Patients we spoke with and the comment cards we received complimented the practice on the availability of appointments with many people telling us they had never waited longer than the next day to be seen. The opening hours were displayed in the practice and on the web-site as were the contact details in the event of an emergency.

GPs were available for home visits for patients who could not come to the surgery and telephone consultations were also offered on a ring-back basis. Repeat prescriptions could be ordered online, over the telephone, in person or through the local pharmacy.

There was a wheelchair and pushchair ramp to the front of the surgery. The practice nurse told us that they were usually aware in advance of when someone with restricted mobility would be visiting the surgery, but that in any event such patients would always be seen in a ground floor surgery.

We saw that the practice web-site had an automatic translation facility which meant that patients whose first language was not English could gain 'one-click' access to information about the practice and about NHS primary medical care. We spoke with a member of the reception staff who showed us how they would access information in other languages on the internet should any new patient arrive at the practice who could not speak English.

Concerns and Complaints

We saw that there was a clear complaints policy on display in the practice and also on the practice website.

People told us they would know how to complain if necessary but that they had never had cause to do so. We noted that there was a process in place for recording and dealing with complaints but that this had only been used on one occasion. This complaint related to the playing of soft background music in the waiting areas and had resulted in a short consultation with the patient participation group, which the practice referred to as a patient representation group (PRG), about whether the music should continue. The PRG feedback showed that the background music was pleasing and welcome and that it helped to prevent patient consultations being overheard through the thin surgery walls. This resulted in the music remaining a feature of the practice waiting rooms.

We saw that there was a whistleblowing policy in place and staff told us they were aware of its purpose. We saw evidence that this policy had been initiated on one occasion where a particular incident had been investigated and dealt with in a robust manner. As a result, clear instructions had been issued to non-clinical staff about providing clinical advice to patients.

Are services well-led?

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

Summary of findings

The practice was well led. There was strong and visible leadership with a good philosophy of care that was shared by all staff.

There were effective governance structures which included regular communication within and external to the practice. However, not all of the practice and clinical meetings were recorded which meant key decisions could not easily be audited.

The practice made use of information acquired directly from patients and information held electronically to manage and improve the provision of services.

There was an active patient participation group which was used effectively by the practice, and feedback from patients was used to help the practice to learn and improve. This practice had called the group the patient representation group (PRG).

Our findings

Leadership & Culture

One of the GPs told us that they had originally established the practice with an aspiration to provide high quality, person-centred care. We noted that this philosophy of care was reflected throughout our discussions with the GP and we saw evidence of where this philosophy had been realised. For example, members of the patient representation group (PRG) we spoke with in advance of our visit, told us that the doctors and staff were caring and compassionate.

All of the other members of the staff team we spoke with during our inspection told us that they shared the GPs vision for providing good quality care and of treating people with dignity, respect and fairness. They told us that it was the principal reason why they were satisfied with their work and pleased to be part of the team.

We looked at the patient charter on display in the reception area and noted that its principal focus was on dignity, respect, equality and treating patients as a partner, involving them in discussion about their care and treatment. We received a high number of comment cards from patients who were visiting the practice on the day of our inspection. All of these comments were positive and the majority reflected people's experience of a caring and sensitive staff team. This showed that the GP's ethos had been understood and put into practice.

Governance Arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business. This included roles such as safeguarding lead and infection control lead. We saw that the practice manager was a 'Caldecott Guardian', the designated person for protecting the confidentiality of patient information and enabling appropriate information-sharing.

The practice employed a document management system that enabled the practice manager to track and account for reviews of key protocols and policies and for storing notes of meetings. We also saw that there were regular practice meetings that enabled decisions to be made about issues affecting the general business of the practice. For example,

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we saw that there was a quarterly general practice meeting attended by all staff where every person was invited to contribute agenda items and where practice issues such as the repeat prescription process and vaccination availability were discussed.

We saw that the practice held monthly clinical governance meetings involving the GPs and the practice manager where decisions about clinical issues were discussed and resolved. This included issues that arose from reviews of data about patients held on the records system. For example, we saw that the meeting in January 2014 had identified the need to investigate frequent attendances at the hospital trust emergency department. This had resulted in a questionnaire initiated by the practice manager in conjunction with the Clinical Commissioning Group (CCG) to determine if any follow-up action might be required for any particular patient. The outcome of this survey was discussed at a later meeting and resulted in such follow-up activity for one patient.

We found, however, that not all practice or clinical meetings were recorded and that the practice relied on emails and computer generated 'tasks' to take forward actions that arose from these meetings. This meant that information relating to improvement actions might not be easy to retrieve and progress against actions could not be accounted for from meeting to meeting.

Systems to monitor and improve quality & improvement

We found that this practice actively participated in a local peer review group of four practices that met regularly to discuss issues that were common among GPs in the area and to promote good practice. For example, we noted that the Arden Medical Centre had contributed information to this group about their audit of their approach to monitoring and treating patients with a history of diabetes in pregnancy. They had also contributed information to a discussion of the effectiveness of giving their personal contact details to patients receiving palliative care.

We also found that the practice made use of a predictive tool known as 'risk stratification' to identify particular patients that might be at high risk. This had been carried out through a monthly review of information generated by the records system by the practice manager. This had resulted in one such patient being identified and a risk management plan being created for that person's care.

These examples showed that the practice made use of information acquired directly from patients and information held electronically to manage and improve the provision of services.

Patient Experience & Involvement

The practice had an active patient representation group (PRG) which met six monthly as well as a group of patients known as a 'Virtual PRG' that were contacted from time to time through email. The practice had conducted its own patient survey using questions that had been agreed by the PRG in December 2013. Patients views were sought on the following topics; opening times, reception, appointments, premises and engagement with the GP. The survey also contained an invitation to make suggestions for improvement.

The majority of patients who responded confirmed they were happy with the service provided and that there were no significant issues. However, a number of improvement actions were agreed with the PRG. For example, we saw that additional training for receptionists on the telephone system had been agreed in order to enable them to respond more effectively to urgent incoming calls.

This showed that the practice had processes in place for engaging with people using the service and for acting on their feedback.

Staff engagement & Involvement

Staff members we spoke with told us that they felt valued by all of the senior team at the practice and that their views were listened to. This included the practice manager's 'open door' policy to discuss any areas of concern or suggestions at any time. We also saw evidence that there was an effective whistleblowing policy in place.

Learning & Improvement

We noted that there was an effective system of appraisal in place which the staff found to be relevant and meaningful. We also saw evidence that there were effective arrangements in place to manage staff performance.

Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

Identification & Management of Risk

The practice had clear and robust systems in place for identifying and managing risks to patients. This included

Are services well-led?

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the use of the risk stratification tool for identifying patients at heightened risk of re-hospitalisation, the use of data from the records system to ensure patients with long term conditions were properly reviewed and the use of a survey to investigate attendances at the hospital trust's emergency department.

In addition to this, the practice had systems in place to identify and manage the risks to patients associated with the level of staffing and their skill, the use of equipment and facilities and the cleanliness of the environment.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice provided a personal caring service for people receiving palliative care. Flexible appointments were available for seasonal flu jabs. Older people who had moved in to care home accommodation retained their GP if this was their choice.

Our findings

The practice provided a caring service for people receiving palliative care. The GPs provided their personal contact details to people approaching the last days of their lives and their families so that any evolving needs could be coordinated directly and personally.

The practice offered flexible seasonal flu jab appointments for older people and those with on-going health problems.

Although the practice was not commissioned to provide a local dedicated GP service to care homes, some older people who were registered with the practice who had moved into such accommodation remained the responsibility of the GPs at this practice if that was their choice.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice supported patients and their carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care.

The review dates of patients with some long term conditions such as heart disease, chronic breathing problems and stroke were monitored to ensure their health needs were regularly considered.

In a very small number of cases, patients with diabetes were not routinely informed of their diagnosis.

Our findings

The practice supported patients with long term conditions and their carers to receive coordinated, multi-disciplinary care whilst retaining oversight. For example, there were good, inter-disciplinary links with community nurses and the MacMillan service for people receiving long term palliative care.

There were weekly diabetes clinics led by the practice nurse. The practice also monitored the review dates of those patients with long term conditions, such as diabetes, heart disease, chronic breathing problems, dementia and stroke. This enabled the practice to recall those patients for a review of their health at the most appropriate time as determined by their own needs. It also ensured that those who chose not to attend could be identified and followed up where necessary.

However, in the case of a very few patients, it had become the practice to initially withhold information about their diagnoses of diabetes where blood test results were borderline. This would only occur for those few patients due to psychological reasons if it was considered that the patient would not benefit from knowing the diagnosis and provided they were monitored and reviewed regularly. A formal diagnosis would be provided to all other patients. Whilst the effect of withholding this information meant that some patients were not initially given the opportunity to be involved in their treatment planning or to provide informed consent, this was, nonetheless, a further example of the patient centred approach taken at this practice.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Women with a history of diabetes in pregnancy were given an additional opportunity for a further blood test and further treatment and advice where necessary.

The practice held childhood immunisation clinics. The practice also held twice weekly walk-in teenage and young adult health clinics.

Our findings

We saw that a clinical audit had been carried out by one of the GPs about their approach to monitoring and treating patients with a history of diabetes in pregnancy. The outcome of this audit was that staff awareness of the condition was heightened and further blood glucose tests were carried out on those people affected. This ensured there were opportunities to diagnose on-going diabetes and to provide appropriate diet and lifestyle advice that had previously been missed.

The practice ran childhood immunisation sessions by appointment as well as weekly antenatal clinics.

The Arden Medical Centre operated a twice weekly teenage and young adult health walk-in service for patients that were registered there and for other young people in the area who were registered elsewhere and who wished a confidential consultation.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

People who were looking after others were supported through a carers assessment with a referral onwards to other services if required.

The adult health screening programme for people aged between 40 and 75 was due to commence in the weeks following our inspection.

Our findings

People who were caring for others were given information in a 'carer's pack' about local services. People who were identified as carers were asked to complete a questionnaire and were given a specific assessment by one of the GPs. If necessary, carers were referred onwards to relevant local social care or health agencies and this ensured that carers and those they were caring for received appropriate support.

The adult health-screening programme was scheduled to start within weeks following our inspection for patients aged between 40 and 75 without any diagnosed long term conditions. The practice had already identified and prioritised their list of patients they would be offering these checks to.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

People could gain access to written information online in different language formats if their first language was not English.

The practice operated a service specifically for those patients who could not get access to primary care elsewhere due to a history of violence.

People from travelling communities and those working in the tourist industry were able to register as temporary patients on a walk-in basis.

Home visits and telephone consultations were available for people who could not get to the surgery. There was also an access ramp for people with restricted mobility.

The practice provided a GP service to many of the people living at a nearby care home for people with learning disabilities.

Our findings

The practice web-site had an automatic translation facility which meant that people whose first language was not English could gain 'one-click' access to information about the practice and about NHS primary medical care.

The practice engaged with the local authorities and the commissioners of primary care to put arrangements in place to see those patients who could not access services due to their history of violence. Such patients were routinely seen as part of pre-planned appointments at the local police station by one of the GPs.

The practice had become a walk-in centre for temporary patients who were visitors to the town and who would not ordinarily have permanent access to primary medical care. These patients included people from travelling communities, those working in the local tourist industry and members of theatre companies.

Doctors were available for home visits for patients who could not get to the surgery and telephone consultations were also offered on a ring-back basis. Repeat prescriptions could be ordered online, over the telephone, in person or through the local pharmacy.

There was a wheelchair and pushchair ramp to the front of the surgery. The practice nurse told us that they were always aware in advance of when someone with restricted mobility would be visiting the surgery and that they would always be seen in a ground floor surgery.

The practice provided a GP service to many of the people living at a nearby care home for people with learning disabilities.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice was about to begin an arrangement with the mental health service to improve patients access to psychological therapy.

Our findings

The practice had been discussing an arrangement with the mental health service for the use of one of the consulting rooms at the practice for an initiative known as Improving Access to Psychological Therapy (IAPT). This would enable local people who were suffering from anxiety or depression, not necessarily the patients of this practice, to gain access to the particular services offered by IAPT.