St Werburgh Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Werburgh Medical Practice on 09 December 2014. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. The practice was also good for providing services for the populations groups we rate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored appropriately reviewed and addressed and learning was routinely shared with staff.
- Risks to patients were assessed and well managed.
- Patient outcomes were at or above average for the locality and good practice guidance was referenced and used routinely.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients were able to book routine appointment s with the GP at a time that suited them. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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 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 at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff were clear of their roles and responsibilities in line with the Mental Capacity Act 2005. Staff had received training appropriate to their roles, any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing a caring service. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect.Staff followed correct procedures to help keep patients' information confidential.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local patient population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had policies and procedures to govern activity. There were systems to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. 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 population group of older people. Nationally reported data showed the practice had outcomes hat were in line with national averages for conditions commonly found amongst older people.

The practice offered personalised care to meet the needs of the older people in its population. The practice work with other health and social care providers and with out of hours providers to ensure continuity of care.

The practice was responsive to the needs of older patients. The GP provided home visits and rapid access appointments for those with enhanced needs. Older patients were offered on the day appointments or telephone consultations. The practice had a policy governing appointments for older patients that helped ensure they were seen by a GP in a timely and appropriate manner.

There were care plans for patients at risk of unplanned hospital admissions as well as patients aged 75 years and over who were vulnerable. The practice was proactive in recognising carers, recorded carer's details and gave support packs to carers.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. There were emergency processes and referrals made for patients in this group who had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice had an electronic register of patients with long term conditions and had a recall system to help ensure patients were called for a review annually. All recall letters were followed up by a telephone call to help patients understand the need to attend reviews. For those patients with the most complex needs GPs worked with relevant health and social care professionals to deliver a joined up multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. There were systems for identifying and following-up vulnerable families and who were at risk. Immunisation rates were good for all standard childhood immunisations.

Appointments were available outside of school hours for children and those with long term conditions. The practice arranged

Summary of findings

appointments and reviews during school holidays where possible. All of the staff were responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice offered a full range of health promotion and screening which reflected the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients between the ages of 40 to 75. The practice had extended opening hours enabling people to make appointments outside normal working hours. Appointments could be booked in advance, online, over the telephone or in person.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for patients with learning disabilities and offered them longer appointments where required. The practice provided an interpreter service for patients whose first language was not English.

The practice worked with multi-disciplinary teams in the case management of vulnerable patients.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Patients experiencing poor mental health were given telephone call reminders on the day of their appointment to remind then to attend their appointment; in the event patients do not want to come into the practice a home visit would be arranged. The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

Summary of findings

Patients who experienced difficulties attending appointments at busy periods they were offered appointments at the beginning or end of the day to reduce anxiety.	

Summary of findings

What people who use the service say

We spoke with fifteen patients on the day of our inspections and reviewed 45 patient comment cards. 31 comment cards were positive about the service patients experienced at St Werburgh Medical Practice. 11 comment cards contained both positive and negative comments and three contained only negative comments. Patients indicated that they felt the practice offered a very good service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. We identified two themes from the negative comments. Patients indicated it was difficult to get through to the practice on the telephone and they were not always able to book an appointment that suited their needs.

There is a survey of GP practices carried out on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 309 survey forms were sent out and 112 were returned. The main results from that survey were:

- Patients said that the last appointment they got was convenient and the practice had scored 95% which was higher than the local CCG average of 85%
- Patients described their overall experience of the surgery was good scoring 84% and this was higher than the local CCG average at 69%
- Patients said they had confidence and trust in the GP they saw which scored 95% which was higher than the local CCG average at 65%
- Patients reported that the experience of making an appointment was good and the practice scored 70% in line with the CCG average
- 81% of patients indicated that they would recommend the practice to others which was higher than the local CCG average of 69%

Patients indicated that they could not always see their GP of choice and scored 39% which was lower than the CCG average at 90%

St Werburgh Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a pharmacist specialist advisor and a second CQC inspector.

Background to St Werburgh Medical Practice

St Werburgh Medical Practice provides primary medical services in Rochester Kent from Monday to Friday. The practice is open between 8.30am - 12.30pm and 3pm to 6pm Monday - Friday. Extended hours from 6.30pm to 7.30pm are available on Tuesday and 7am - 8am on Wednesday and Thursday. The nurses also offer extended hours each Friday 7am - 8am and alternate Tuesdays 7am - 8am. Balmoral Gardens, Community Healthy Living Centre, Gillingham is closed on Thursday afternoon and Stoke Village Hall, Lower Stoke, Rochester is closed on Wednesday afternoon.

St Werburgh Medical Practice is situated within the geographical area of NHS Medway Clinical Commissioning Group (CCG). St Werburgh Medical Practice is responsible for providing care to 11,700 patients across three practices. The practice had a higher than average working age population. The practice is a training practice and has its own dispensary.

Services are delivered from:

98 Bells Lane

Hoo, St Werburgh

Rochester

Kent

ME3 9HU

Balmoral Gardens

Community Healthy Living Centre

Gillingham

Kent

ME7 4PN

Stoke Village Hall

Mallard Way

Lower Stoke

Rochester

Kent

ME3 9ST

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our 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

Detailed findings

the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 December 2014. We reviewed information provided on the day by the practice and observed how patients were being cared for. We spoke with 15 patients, eight members of staff and three GPs. We spoke with a range of staff, including receptionists, the practice manager, practice nurses, and the health care assistant. We talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems to monitor patient safety utilising all the data and information available to them. Reports from NHS England indicated that the practice were in line with national standards for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as a highly achieving practice. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events.

There was a system to report, investigate and act on incidents of patient safety, this included identifying potential risk. Staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that action had been taken.

Staff had access to multiple sources of information to help enable them to maintain patient safety and keep up to date with best practice. The practice had systems to respond to safety alerts. We looked at one safety alert from March 2014, relevant to general practice and saw that it had been received, recorded and dealt with properly. This was a medium practice and staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care. The practice had additional systems to maintain safe patient care specifically of those patients over 75 years of age, with long term health conditions, learning disabilities, vulnerable children and those with poor mental health. The practice maintained a register of patients with additional needs and / or who were vulnerable and closely monitored their needs in conjunction with other health and social care professionals where required. For patients who required annual reviews as part of their care the practice operated a system to help ensure reviews took place in a timely manner.

Learning and improvement from safety incidents

The practice had a system for reporting and recording significant events. Investigations had been carried out and the impact of each event had been analysed resulting in the changes required and learning was routinely shared with staff. All staff told us the practice was open and willing to learn when things went wrong and provided examples of where they had been supported following significant events

Staff told us they received updates on safety alerts relevant to their roles via emails. Action had been taken and the outcomes were recorded and audited. Staff told us they received regular updates as part of their on-going training and self-directed learning.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff told us that if they had concerns they would seek guidance from the GP who was the safeguarding lead or seek support from a colleague as soon as possible.

The practice had a detailed child protection and vulnerable adult's policy and procedure that included reference to the Mental Capacity Act 2005.

Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to help ensure information was shared between social and health care professionals promoting continuity of care.

The GP who was the safeguarding lead had completed training to level three and working closely with the practice manager who linked with the local authority safeguarding team. Staff at the practice were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside the school health team and social workers.

The practice had a chaperone policy. Staff who acted as chaperones had received relevant training and were clear of their roles and responsibilities. Records demonstrated that all staff who acted as chaperones had criminal records checks through the Disclosure and Barring Service (DBS).

Medicines management

The practice had dispensaries at two sites. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were refrigerators in the dispensaries and in the treatment rooms for any items requiring cold-storage and we saw that there was

monitoring of temperatures. When vaccines were transported between the premises a validated cool box was used, this ensured that the cold chain was maintained, ensuring that these medicines would be safe and effective to use. We recommend that systems are put in place to monitor room temperatures.

There were processes in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of patient group directions and evidence that nurses had received appropriate training to administer vaccines. There were also appropriate arrangements for the nurses to administer medicines that had been prescribed and dispensed for patients including administration protocols.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed safely and effectively. All prescriptions were reviewed and signed by a GP before they were given to the patient or dispensed. We saw one medicine handed to a patient without a manufacturer's Patient Information Leaflet, whilst we were at the practice the dispensary staff photocopied the leaflet to ensure that this information would be available in the future.

Prescription pads and blank prescription forms for printing were stored securely, and serial numbers were recorded on receipt and when they were issued to the GPs and the dispensary. The practice held controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures that set out how they were managed. These were always followed by the dispensary staff. There were arrangements for the destruction of controlled drugs.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Cleanliness and infection control

The practice was clean and tidy. There was a dedicated lead for infection control and they carried out audits to help ensure the practice had complied with recognised standards. All the patients we spoke with were happy with the level of cleanliness within the practice.

The practice had up to date policies and procedures to govern infection control. These included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

Certification held in staff files showed that staff had received infection control training. All staff

we spoke with were clear about their roles and responsibilities for maintaining a clean and safe

environment. Rooms were well stocked with gloves, aprons, alcohol gel, and there were sufficient hand washing facilities throughout the practice.

The practice only used single use instruments that were stored correctly. Stock rotation was employed to reduce the risk of out of date sterile items being used.

Maintenance was managed by the building management team as was clinical waste. The practice met with the building management team routinely and were able to raise any concerns as and when required.

We looked in two consulting rooms. Both the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. The dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

Equipment

The practice manager had a plan to help ensure all equipment was effectively maintained in line with manufacturers' guidance and calibrated where required. We saw maintenance contracts for all equipment. Staff we

spoke with told us they had access to the necessary equipment and were skilled in its use. Checks were carried out on portable electrical equipment in line with legal requirements.

Staffing and recruitment

There were formal processes for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy which was up-to-date. We looked at the recruitment and personnel records of four staff. Recruitment checks had been undertaken that included a check of the person's skills and experience through their application form, personal references, identification, criminal record checks through the Disclosure and Barring Service (DBS) and general health status, including, where relevant, an immunisation record.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practise.

We were satisfied that (DBS) checks had been carried out appropriately for all staff to help ensure patients were protected from the risk of unsuitable staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Identified risks were included on a risk log, reviewed and managed by the practice manager who liaised with the buildings manager where required.

The practice manager had clear staffing levels identified and procedures to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff, only using locum staff when absolutely necessary.

Arrangements to deal with emergencies and major incidents

Staff told us and records confirmed that they were trained in basic life support. Emergency equipment and emergency medicines were available at all three practices. However, only two practices had access to medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). This was because the practice was located in a village hall and that the risk of the equipment being tampered with was high. The practice had carried out risk assessments with regard to the procedures for staff to apply in the event of a medical emergency happening. Staff confirmed that an ambulance would be called and manual resuscitation techniques used. This decision had been made after careful consideration and a balance of risks analysed. Staff told us that these medicines and equipment were checked regularly and we saw records that confirmed this.

There were inventories of emergency medicines and emergency equipment, however, inventories of emergency equipment did not reflect the emergency equipment available. For example, we saw that emergency equipment included airways (used to maintain a patient's airway in an emergency) and a pocket face mask (used by staff to deliver rescue breaths to patients who were not breathing). These items of equipment were not listed on the emergency equipment inventory. Two of the inventories also did not state quantities of all medicines and equipment that were to be available in an emergency nor the size of equipment such as syringes and hypodermic needles. Staff checking emergency medicines and emergency equipment could not, therefore, be sure all items were present as inventories were incomplete for them to refer to. All emergency medicines that we looked at were within their expiry date. However, some emergency equipment held at two of the were out of date. The practice confirmed following our inspection that the medicines in question had been replaced.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the building management, CCG and associated health and social care professionals.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and regular fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The staff we spoke with and the evidence we reviewed confirmed that these approaches were designed to help ensure that each patient received support to achieve the best health outcome for them. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Patients with chronic diseases such as asthma received a health review on an annual basis. The national Quality Outcome Framework (QOF) data demonstrated that 88.75% of patients on the diabetes register had received a dietary review. For patients with asthma 76.13% of patients on the register had received an assessment of the efficacy of their asthma control.

The GP and nurse were aware of the issues and discussed the challenges of the population group in complying with healthy lifestyle advice. The nurse provided us with a number of examples of patient education they were providing during consultation for chronic illness and healthy lifestyle changes such as healthy diet and exercise regimes.

The practice maintained a register of patients with a learning disability to help ensure they received the required health checks. All patients with learning disabilities had annual reviews carried out by the nurse or GP who explained to us they used the nationally recognised Cardiff Health Check to help ensure a comprehensive review was carried out encompassing emotional and physical wellbeing.

The GP carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis and provided health improvement guidance. The QOF data provided evidence that the practice responded to the needs of people with poor mental health, above the average for the local CCG, by ensuring, for example they had access to health checks annually.

Practice data demonstrated that child development checks were offered at intervals that were consistent with national guidelines and policy. For children of refugees or new into the country, where records were not clear and up to date for child immunisation, there was a policy as well as guidance from the Health Protection Agency to help ensure children attending the practice had access to appropriate vaccinations.

Information available to staff, minutes of meetings and our discussions with staff demonstrated that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts via emails and nursing staff told us they received regular updates as part of their on-going training.

Clinical staff were able to clearly describe to us how they assessed patients' capacity to consent in line with the Mental Capacity Act 2005. The practice worked within the Gold Standard Framework for end of life care and held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers.

Management, monitoring and improving outcomes for people

Assessments of care and treatment as well as support provided, enabled patients to self-manage their condition, such as diabetes or chronic obstructive pulmonary disease (COPD).

A range of patient information was available to patients which helped them to understand their conditions and treatments. Staff said they could openly raise and share concerns about patients with colleagues to help enable them to improve patients' outcomes.

The practice monitored patient data which included full clinical audits that demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as asthma and heart failure. They were also monitoring that childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 93% of children at 24

Good

Are services effective?

(for example, treatment is effective)

months had received the measles, mumps and rubella (MMR) vaccination. Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement.

The practice had systems to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long-term medication.

Patients told us the staff at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Personnel records we reviewed contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records. We also saw that Disclosure and Barring Service (DBS) checks (criminal records checks) had been carried out on all staff.

We saw examples of the induction training staff underwent on commencement of employment with the practice and there was specific orientation information available for locum GPs. Staff told us that they received yearly appraisals and GPs said they carried out relevant appraisal activity that now included revalidation with their professional body at required intervals. We saw records that confirmed this.

There was evidence in staff files of the identification of training needs and continuing professional development. The practice had processes to identify and respond to poor or variable practice including policies such as the management of sickness and absence policy as well as a disciplinary procedure.

Equipment and facilities were kept up to date to ensure staff were able to deliver effective care to patients.

Working with colleagues and other services

Staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and help ensure there were care plans for the most vulnerable patients. The GP and the practice manager arranged multi-disciplinary meetings where required. Communication on a daily basis with community midwives, health visitors and district nurses took place by telephone and fax. The practice had identified some difficulties contacting health visitors and were working with the CCG to address this. The practice worked with other service providers to meet patients' needs and manage those of patients with complex conditions.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

For patients at the end of their life the practice worked closely with the palliative care team to help ensure co-ordinated care. Patients who required emotional support were referred to counselling services.

Information sharing

The practice used an electronic system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to help enable patient data to be shared in a secure and timely manner. There were also electronic systems for making referrals such as the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice provided the 'out of hours' service with information, to support patients and uphold their wishes. For example, patients receiving 'end of life care.' Information received from other agencies, such as accident

Good

Are services effective?

(for example, treatment is effective)

and emergency or hospital outpatient departments, was read and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care, where they provided a summary care record and information that was shared with local care services and out of hour providers. For the most vulnerable 2% (a nationally agreed percentage) of patients over 75 years of age, and patients with long-term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

The practice operated a policy and procedure for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations. There were policies and procedures for staff to refer to with regard to the Mental Capacity Act 2005 (MCA) and staff had completed training. Clinical staff had an understanding of the principles of gaining consent, were able to identify clearly their roles and responsibilities in line with the MCA and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There were forms for which consent other than implied consent was recorded. This consent form, once signed was scanned into patients' notes.

Health promotion and prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check with the health care assistant.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion. Staff promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. Health promotion formed a key part of patients' annual reviews and health checks. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice used recognised guidance to help ensure patients were followed up in a timely manner if any risk factors for disease were identified at the health check.

The nurses provided lifestyle advice to patients which included dietary advice for raised cholesterol, alcohol screening, weight management, sexual health and smoking cessation.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. The practice operated a children's immunisation and vaccination programme. There was a clear policy for following up non-attenders by the practice staff.

The practice's performance for cervical smear uptake was 88.2%, which was in line with national averages and slightly higher than the CCG average. There was a policy to offer telephone reminders for patients and follow up those who did not attend.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception, staff made contact with patients to establish if the patient required a telephone consultation or visit. Any patient aged 75 or known to be vulnerable received a telephone call from the GP on the day.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs. We spoke with fifteen patients and reviewed 45 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used and who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw all phone calls from and to patients were carried out in a private area behind reception we were told this helped to maintain patient confidentiality. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. We observed staff speaking to patients, with respect.

We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the rooms at the side of reception. All the patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff.

Looking at the results from the GP Patient Survey 2013, 93% of respondents found the receptionists at this surgery helpful. Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones, modesty sheets to maintain patient's dignity. We found all rooms had dignity screens or lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive.

Patient comment cards also indicated patients had sufficient time during consultations with staff and felt listened to. The results from the National GP Patient Survey showed 90% of respondents say the last GP they saw or spoke to was good at listening to them. Also 82% of respondents stated the GP they saw or spoke to was good at involving them in decisions about their care and treatment.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 85.7% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. The nurse took the lead on developing care plans for those over 75 years of age. For those vulnerable patients at risk of unplanned hospital admissions care plans had been developed and these were reviewed every three months. Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions about their care.

We noted where required, patients could book extended appointments. For example, reviews of patients with learning disabilities or multiple conditions to ensure staff had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the National GP survey 88% of respondents stated the last GP they saw was good at giving them enough time and 83% stated the last GP they saw or spoke to was good at treating them with care and concern.

Good

Are services caring?

The practice had identified within their patient population many families who cared for an elderly relative within the home and were proactive in identifying carers establishing a carer's register and providing carers with a support pack.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved families were visited by a GP and provided with support.

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 patient's needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered.

The practice worked with patients and families and in a joined up way with other providers to deliver palliative care and ensured patient's wishes were recorded and shared, with consent, with out of hours providers at the end of life. The practice made reasonable adjustments to meet patients' needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments. Where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or through requesting repeat prescriptions with staff at the reception desk.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). Patients had indicated that they would like more access to appointments. The practice had installed extra telephone lines as well as a bypass telephone number for patients on care plans. This number allowed them to contact a GP or nursing staff directly and so helped to reduce emergency admissions to hospital. Extra staff had been provided to man the extra telephone lines during the busiest periods. Extra GP sessions had been added to help with the demand. The PPG had carried out a survey which included questions regarding these new arrangements and of the patients that had taken part 42% responded excellent, 32% very good and 21% good.

Tackling inequity and promoting equality

The practice was located on the ground floor of a building with easy access to the entrance. The practice was easily accessible by wheelchair and prams. Accessible toilet facilities were available for all patients attending the practice.

The practice had a predominant population of English speaking patients although it was able to cater for patients attending for consultations whose first language was not English through translation services. The practice also had access to a telephone translation service.

The practice provided extended appointments where necessary and appointments were available from 7am to 8.00am on a Wednesday and Thursday and 6.30pm to 7.30pm Tuesday to enable patients to make appointments outside of normal working hours.

Access to the service

Appointments were available from 9am to 5.30pm Monday to Friday with extended hours Tuesday 6.30pm to 7.30pm and Wednesday and Thursday 7am to 8am. Patients were able to make appointments in advance, one the day, online and in person at reception or over the telephone. On the day emergency appointments were available by telephoning the practice or booking online. When all appointments were filled, reception staff took patients details which were followed up by the GPs and where required same day appointments or telephone consultations were arranged.

For vulnerable patients there was an alert system to help ensure whatever time of day they phoned, if required a same day appointment was provided. All children under five were be seen on the day. Older patients who walked into the practice for an appointment, wherever possible were seen by a GP the same day.

Comprehensive information was available to patients about appointments in a practice leaflet. Information included how to arrange urgent appointments and home visits. Home visits were available for patients each day by telephoning the practice before 10am. There were also arrangements to help ensure patients received urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours NHS 111 service was provided to patients.

Longer appointments were available for patients who needed them such as those with long-term conditions or patients with learning disabilities. This included appointments with the GPs or nurses. The majority of patients we spoke with were satisfied with the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment system with the only concern raised were via comment cards, Six patient comment cards indicated that patients found it difficult getting through to the practice on the telephone. Five patient comment cards indicated that patients were not always able to book an appointment that suited their needs. The practice was monitoring access and had increased the number of GP sessions. This was being analysed to see if the increase was sufficient or deficient. The National GP survey showed that 84% of patients were able to get an appointment to see or speak to someone the last time they tried and 95% said the last appointment they got was convenient. Results from the practice survey carried out throughout 2014 showed that patients were generally happy with the appointment system.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handled all complaints in the practice. We looked at three complaints received over the last twelve months. Staff were able to describe how they responded to any complaint made and how they followed their complaints policy and records we viewed confirmed this. The practice could demonstrate that they had learned from some of the complaints they had received.

Complaints information was available in the practice leaflet in the waiting area. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

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 beneficial outcomes for patients. Details of the vision and practice values were part of the practice's aims, objectives and statement of purpose. These values were clearly displayed on the practice website. The practice vision and values included providing personalised, effective and high quality general practice services.

The practice demonstrated a commitment to compassion, dignity, respect and equality. This was demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with eight members of staff who all expressed their understanding of the core values and there was evidence that the latest guidance and best practice was being used to deliver care and treatment.

Governance arrangements

The practice had policies and procedures to govern activity and these were available to staff within the practice. We looked at twelve of these documents and saw they were up to date and reflected current guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, the nurses shared the lead for infection control and one of the GPs was the lead for safeguarding. We spoke with eight members of staff and they were all 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 made use of data provided from a range of sources including the clinical commissioning group (CCG) and the national patient survey to monitor quality and outcomes for patients such as services for avoiding unplanned admissions. The practice used the range of data available to them to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) data to measure their performance.

The QOF data for this practice showed it was performing in line with national standards. The Practice manger and GPs met on a regular basis to discuss practice issues, significant events and complaints. Where required multi–disciplinary meetings with external health and social care professionals were arranged. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice had an on-going programme of clinical audits which it used to monitor quality as well as systems to identify where action should be taken. For example, an audit revisit which looked at patients that had received shoulder injections and the success of their treatments. The results of the audit compared to the previous year were, improved management of shoulder problems and avoidance of unnecessary referrals to secondary care.

The practice held monthly staff meetings and governance meetings. Minutes from the last three meetings demonstrated that performance, quality and risks had been discussed. The practice had arrangements for identifying, recording and managing risks. There were records demonstrating that maintenance and equipment checks had been carried out over the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufactures' guidelines. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented to mitigate risks.

Team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice, they had the opportunity to raise issues at team meetings and there was always someone to speak with to seek support, advice or guidance.

The practice had human resources documents that guided staff such as a recruitment policy and an induction programme. Other documents were available to guide staff that included information on health and safety, equality, leave entitlements, sickness, as well as prevention of bullying and harassment. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice and said they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we

Are services well-led?

Good

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

spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. All the staff had responsibility for different activities such as checking on QOF performance.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, patient surveys, suggestions, compliments and complaints.

We reviewed the results of the national patient survey carried out in 2013/14 and noted 84% described their overall experience of the practice as good.

The practice had an active patient participation group (PPG) which was beginning to take shape as the group were currently encouraging other patients to join and were arranging a coffee morning which was well advertised throughout the practice. The PPG had made suggestions with regard to access and appointments and the practice had made changes as a result.

Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff policies file.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan.