Church View 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.

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

Church View Medical Centre was inspected on Wednesday 26 November 2014. This was a comprehensive inspection.

There were two GP partners at this practice (one female and one male), with a team of staff in place to provide a service to approximately 2,200 patients in the village of Broadway and the surrounding areas of Horton, Ilminster and Hatch Beauchamp. The practice also had a dispensary. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

The practice was well led and responded to patient need and feedback. There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group, who ensured patient feedback was relayed to the practice and that comments were acted upon.

Patients liked having a named GP, which they told us improved their continuity of care. The practice was clean, well-organised, was purpose built with good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

Feedback from patients about their care and treatment was consistently positive. We observed a non-discriminatory, person centred culture. Staff told us they felt motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

Summary of findings

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of mental capacity and safeguarding concerns to make decisions about care and treatment, and the promotion of good health.

Suitable recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out thoroughly. There was a culture of further education to benefit patient care and increase the scope of practice for staff.

Documentation received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Actions were taken in response to such events showing that learning and improvements had taken place.

In relation to areas for improvement, the provider should:

- Training in the workings of the Mental Capacity Act (2005) should be extended to all practice nursing staff.
- The practice would benefit from formalised clinical meetings to ensure learning is evaluated.
- The provider should ensure that procedures in place for handling controlled drugs are always followed.

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.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Significant events and incidents were investigated systematically and formally. Reporting of learning for the staff team as a result of significant events was not always clear because events were not consistently discussed with the whole staff team.

Risks to patients were assessed and well managed. There were enough staff to keep people safe and to provide an unhurried service with time to listen to patients' needs. Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. There were no staff vacancies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments were performed when a decision had been made not to perform a criminal records check on administration staff.

Staff were aware of their responsibilities in regard to safeguarding. GPs had received training in the Mental Capacity Act (2005) and had good awareness of how to apply the act during their clinical practice. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management of medicines within the practice.

The practice was clean, tidy and hygienic. Arrangements were in place that helped ensure the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

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.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both national institute for health and care excellence (NICE) guidelines and other locally agreed guidelines.

Summary of findings

Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients. For example, the practice held monthly Gold Standard Framework meetings with members of community health professionals to plan palliative and end of life care for patients with life limiting illnesses, which put the patients' views at the centre of their care planning.

People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes. For example, by completing assessments of patients at risk of fracture from osteoporosis in order to offer additional screening services and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. The practice had a patient participation group (PPG) that ensured patients' views reached the practice and that comments and suggestions were heard and acted upon.

Staff were motivated and inspired to offer kind and compassionate care. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. We received comments about the practice from 24 patients; all comments about the caring attitude of staff were positive and complimentary.

Views of external stakeholders were very positive and aligned with our findings.

Information was provided to help patients understand the care available to them. Leaflets for a range of medical conditions and contacts for support services were displayed in the waiting areas. People with long standing health conditions or vulnerable patients had individual care plans to help support and manage their needs.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Patients told us that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of complaints being responded to in a timely way and resolved to the satisfaction of the person who had complained.

The practice had developed links with village advocacy services for vulnerable or housebound patients. Regular consultation between the practice and village groups ensured vulnerable patients had access to GP services when they needed it.

Are services well-led?

Good

The practice is rated as good for being well-led.

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity and held regular governance meetings to share learning from any events.

There were systems in place to monitor and improve quality and identify risk.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Patients aged 75 and over had their own allocated GP but could also see an alternative GP if they preferred. Pneumococcal, shingles and flu vaccines were provided at the practice. The GPs ensured they visited housebound patients on their caseload and practice nurses visited housebound patients in their homes to administer vaccinations. The practice had a dispensary. This ensured patients could obtain their prescribed medications at the practice as it was situated in a rural setting which was a set distance from a pharmacy. Pharmacy staff also on occasion delivered prescribed medicines to housebound patients who needed medicines urgently. The GPs visited older patients who required a visit following discharge from hospital or arranged for the community matron to do this on their behalf if appropriate.

Clinics specifically for older people were not held at the practice, but treatment was organised around the individual patient and any specific medical condition they had.

The practice had a system to identify older patients and was appropriately involved in the local complex care team (CCT). Vulnerable patients were discussed at meetings held on alternate weeks to identify and review any patients at risk. The work undertaken by the GP team had contributed to the practice's participation in the national initiative to avoid unplanned admission to hospitals by providing an enhanced service.

The practice website included a number of links containing extensive information about the promotion of health for medical conditions which affect older people.

Consulting rooms were located on the ground floor, with level access, avoiding the need to climb stairs. In waiting areas there were chairs of varying heights, some with arms, for ease of use for older patients with mobility problems.

People with long term conditions

Good

The practice identified patients who might be vulnerable, including those with multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance.

Patients with long term conditions had a nominated GP and tailor-made care plans in place. Patients were pleased with the care

they received for their long term conditions and were offered specific clinics for monitoring and treatment of conditions. These included warfarin monitoring, asthma, diabetes, family planning and ante-natal care. Health promotion for patients at the practice included those with long term conditions.

The diabetic clinics supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style was provided. Patients were issued with insulin information cards which could be used for reference if the patient was on holiday or away from the practice. Diabetic patients had a twice yearly health check.

Home visits and medication reviews were provided for patients with long term conditions who had been recently discharged from hospital.

Patients receiving certain medicines were able to access screening services at the practice to make sure the medication they received was effective. This included, for example, patients on warfarin medicine (a blood thinning medicine) early or mid-week appointments to check blood levels. This was so that results were back before the weekend allowing any adjustments to medicines to be made before the weekend closure of the practice.

The practice used a specific computerised patient record system allowing out of hours service providers to access information on specific patients with the aim of treatment being seamless for the patient. GPs and out of hours doctors were thus aware of any treatment that had been given to people with long term conditions or those at the end of their life.

Families, children and young people

Good

There were baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a midwife who held clinics at the practice. The midwife had access to the practice computer system and could speak with a GP should the need arise. The practice also had relationships with health visitors and the school nursing team, and was able to access support from children's workers and parenting support groups.

Parents were invited to bring their children to regular developmental check-ups with their GP. The practice referred patients to a local family and child service to discuss any vulnerable babies, children or families.

Summary of findings

Men, women and young people had access to a full range of contraception services. Men, women and young people had access to sexual health screening including chlamydia testing and cervical screening for women.

There were not specific clinics or services for younger people but staff were aware of steps to take to report safeguarding concerns about children and young people. All staff had attended safeguarding training appropriate to their roles.

Working age people (including those recently retired and students)

Good

Health checks were available to patients aged between 40 and 74.

The practice offered one evening surgery until 7pm, outside of normal opening times to help patients of working age attend appointments. Patients could request appointments in person or by phone. Telephone consultations were also available.

Travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for patients at risk.

The staff carried out opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicine reviews. The practice also offered age appropriate screening tests including for prostate cancer and cholesterol testing.

People whose circumstances may make them vulnerable

Good

The practice had a very low number of registered patients with a learning disability. They were offered an annual health check, during which their long term care plans were discussed with them and their carer if appropriate.

Patients for whom English was not their first language were offered interpretation and translation services. The practice had low numbers of registered patients speaking English as a second language.

Patients with alcohol and drug addictions were referred to the local treatment service.

GPs had often referred vulnerable, housebound patients to the community nurses who visited them at home to assess their needs. Staff from the practice also visited patients at home when they have

Summary of findings

expressed reluctance to attend the practice for either emotional or health reasons. The practice had patients registered at two local nursing homes, where GPs made regular calls to review these patients' health needs.

The practice worked with community health care professionals including physiotherapists and mental health workers to make sure vulnerable patients were visited in their homes to assess needs and facilitate provision of any equipment, mobility or medication.

People experiencing poor mental health (including people with dementia)

Good

The practice had a register of patients with mental illness, depression and dementia. All were offered regular checks, opportunistically and by invitation. For example, homeless patients with mental health needs were able to see a GP on the day if they came to the practice reception.

GPs, nursing and administrative staff had attended dementia and learning disability awareness sessions.

Mental health medicine reviews were conducted to ensure that patients' medicines remained appropriate and that the dose was still correct. Blood tests were regularly performed on patients receiving certain mental health medications to provide the GP with the information they needed to adjust the dosage.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection and three representatives from the practice's patient participation group (PPG).

In addition, the practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 20 comment cards. The cards contained positive comments about the friendliness of the staff, ease of making appointments, helpful medical advice, prompt referrals to treatment, maintaining the dignity and respect of patients, listening to patient concerns and a pleasant practice environment.

Positive statements from comment cards were reflected during our conversations with patients. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, said they had no complaints and got good treatment. Patients told us that the GPs, nursing and care staff were excellent and in particular told us the appointments were unhurried, allowing them time to fully discuss their health needs with the practice staff.

Patients were happy with the appointment system. Some people said they preferred to see their named GP but appreciated this was not always possible. Appointments with alternative GPs were offered. Patients appreciated the service provided and told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the information provided and the practice website was good.

Areas for improvement

Action the service SHOULD take to improve

- Training in the workings of the Mental Capacity Act (2005) should be extended to all practice nursing staff.
- The practice would benefit from formalised clinical meetings to ensure learning is evaluated.
- The provider should ensure that procedures in place for handling controlled drugs are always followed.

Church View Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Church View Medical Centre

Church View Medical Centre provides a service to approximately 2,200 patients in the village of Broadway and the surrounding areas of Horton, Ilminster and Hatch Beauchamp.

There were two GP partners at this practice (one female and one male), with a team of staff in place. GP partners hold managerial and financial responsibility for running the business. Employed at the practice was a practice manager, an assistant practice manager who was also the dispensary manager, three pharmacy dispensers, two practice nurses and a health care assistant and four administrative/receptionist staff. The practice had a dispensary. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy. .

Patients using the practice also had access to community staff including, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

Church View Medical Centre is open between Monday and Friday 8.30am – 6:00pm. There was extended opening hours on one evening per week until 7.00pm. Outside of these hours a service is provided by another health care provider.

There was a same day illness clinic for patients and telephone request service for patients who wish to discuss their treatment with a GP over the telephone. Routine appointments are bookable up to six weeks in advance.

The practice also offers a minor surgical procedures service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before conducting our announced inspection of Church View Medical Centre, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

Detailed findings

We requested information and documentation from the provider which was made available to us both before and during the inspection.

We carried out our announced visit on Wednesday 26 November 2014. We spoke with four patients, three members of the patient participation group (PPG) and eight staff at the practice during our inspection. We collected 20 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, two GPs, three pharmacy staff, one receptionist and one practice nurse. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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 poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice had a systematic process in place for reporting, recording, monitoring and communicating findings from significant events. The practice kept records of significant events that had occurred and used these as part of a quality assurance process to monitor any trends although findings were not always discussed with the whole staff team. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it.

Learning and improvement from safety incidents

From speaking with staff there was evidence that appropriate learning had taken place where necessary. GPs discussed the incidents as they occurred informally. We were given two examples of where practice and staff action had been prompted to change as a result of incidents in the last 12 months. These included changes in protocols and additional checks for accuracy following prescribing of medicines.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding. GPs were trained in safeguarding to the appropriate advanced level to ensure they had comprehensive knowledge of how to identify potential abuse and how to report their concerns.

There were policies in place to direct staff on when and how to make a safeguarding referral. This included flow charts displayed for staff reference. The policies and flow charts included information on external agency contacts, for example the local authority safeguarding team.

Practice staff said communication between health visitors was via telephone or email as health visitors.

Staff had received safeguarding training and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

Medicines Management

The practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises.

The practice had a dispensary that was open for a period each morning and afternoon Monday to Friday. We found that medicines were stored securely and were only accessible to authorised staff. Medicines were stored at the required temperatures. Staff monitored the temperatures of the medicines refrigerators to make sure these medicines were safe to use.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. These were followed in practice. However staff told us that on some occasions they may not have the medicines checked by another person before they were given to a patient. This did not follow the practice procedure and increased the risk that the wrong amount of medicine could be given to a patient.

Suitable secure storage was available for controlled drugs, access to them was restricted and the keys held securely. Arrangements were in place for the destruction of out of date controlled drugs and of those returned by patients.

Directions in line with legal requirements and national guidance were in place for nurses administering vaccines. We saw up to date copies of these directions. This helped to ensure patients were treated safely. Staff told us that the healthcare assistant had also received training to give a small number of injections using patient specific directions from the patient's doctor. The practice had a protocol for ensuring vaccinations administered by health care assistants were given under a patient specific direction. This included staff having a competency certificate authorised by a competent supervisor.

The practice was signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high

quality services to patients of their dispensary. We saw evidence that dispensary staff had received training for their role. Staff received annual appraisals and a check of their competence, which helped to ensure they were working to the correct, safe standard.

Safe systems were in place for the generation of repeat prescriptions. Staff told us they could generate repeat prescriptions but 'acute' prescriptions for occasional medicines could not be generated by dispensary staff. These were generated by the doctor. This helped to make sure patients received the correct medicines. Patients had a number of ways to request their repeat prescriptions. Prescriptions were available to collect within 48 hours.

Repeat prescriptions had an annual review date. Staff told us they would alert the patient that a medicines review was needed, but they were still able to provide a repeat prescription. Procedures in place allowed staff to continue to provide repeat prescriptions for three to four months before they alerted the doctor of the medicines not being reviewed. This increased the risk that patients may not have their medicines reviewed in a timely way.

Dispensary staff told us safeguards were in place to make sure that some high risk medicines were identified and regularly monitored. For example they had books for each patient prescribed one particular medicine where they recorded the patients' blood results and the dates medicines were dispensed. Patients prescribed another medicine requiring regular blood tests had checks made by the practice nurse.

Appropriate systems were in place for the safe dispensing of medicines. Dispensing staff were aware that prescriptions should be signed before being dispensed. Systems in place in the dispensary enabled this to happen. We saw that dispensed prescriptions awaiting collection had all been signed by the doctor.

The practice had a supply of emergency medicines. These were checked regularly to make sure they were in date and safe to use.

Cleanliness & Infection Control

The practice had appropriate policies and procedures on infection control which included managing spillages, needle stick injury, waste, cleaning and control of substances hazardous to health. We spoke with the nurse infection control lead at the practice. They collaborated in auditing effectiveness of infection control at the practice. Audits were carried out annually. Staff had access to supplies of protective equipment such as gloves and aprons, disposable couch roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control within the last 12 months.

Reception staff told us that any spillages in the waiting room or entrance were dealt with by the nursing staff straight away. Spillage kits were kept in the treatment room and disposable aprons and gloves were available. The entrance to the practice and the waiting room was visibly clean and tidy.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There were hand washing posters on display to show effective hand washing.

Clinical waste and sharps were being disposed of in safe manner. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. Patient couches were height adjustable enabling patients with mobility problems to be able to use them during consultations.

Portable appliance testing (PAT) had taken place. PAT ensures equipment safety by routinely checking electrical appliances for safety by an external contractor within the recommended two yearly cycle.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Good

Are services safe?

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. Many staff at the practice had been there for a number of years. There were no staff vacancies. For patient continuity a small team of regular locum GPs were used to cover GP absences. GPs told us they also covered for each other during shorter staff absences.

The practice used a clear system to ensure the workload for staff was shared equally and cover was available when GPs were on leave or absent.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview and interview notes kept to show the process was fair and consistent. Once in post staff completed a job specific induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal records checks via the Disclosure Barring Service (DBS) were only performed for GPs, nursing staff and administrative staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

The practice had disciplinary procedures to follow should the need arise.

The registered nurses' Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented their response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had been included on the basic life support training sessions.

A system was in place for the reception staff to summon immediate help if a patient became unwell or collapsed in the waiting room. Reception staff told us they felt confident when dealing with difficult situations or the very occasional challenging behaviour of patients at the reception desk, they felt well supported by the staff team. The practice had an accessible toilet. We noticed the panic alarm sound in the toilet was quiet and the visual alarm was partially obscured by a low ceiling. We brought this to the attention of the practice manager who told us they would look into this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, the practice had an on line formulary to access guidance. Emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance, there were informally held clinical meetings where latest guidance would be discussed. We saw that where required GPs had good knowledge of and followed guidance from the Mental Capacity Act (2005). However, not all nursing staff could verbalise a sound knowledge of such guidance and further training is advised. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area.

Reception staff told us that blood test results were flagged on the computer system until a GP had looked at them. There was no backlog of results waiting to be seen and if this were the case a GP would receive a reminder to look at test results.

Letters and other mail had been scanned and saved electronically, after which the hard copies were passed to the GP. There was no back log of post waiting to be acted on.

Management, monitoring and improving outcomes for people

The GPs used the QOF data to monitor the service they provide but also to improve and identify where additional services may be necessary. For example, providing additional clinics for patients.

The practice had a system to identify more vulnerable patients and the GPs were included in a local complex care team (CCT) who met to discuss vulnerable patients, as well as those at risk. The team also included community nurses and social workers and village advocacy services. The work undertaken by the GP and team contributed to the practice's participation in the national initiative to avoid the need to admit patients to hospital.

There was evidence of regular clinical audit, which was used by GPs for revalidation and personal learning purposes. Examples of recent clinical audits included vaccine 'cold chain' storage, osteoporosis and risk of falls and an audit of all minor surgery procedures in the last 12 months.

Effective Staffing, equipment and facilities

Both GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed.

Nursing and administration staff had received an annual formal appraisal and kept up to date with their continuous professional development programme. We saw documented evidence to confirm that this process was used.

A process was in place to ensure clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for the role of each person.

The staff training programme was monitored to make sure staff were up to date with training the practice had listed as mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff training was discussed at appraisal and staff could attend any relevant external training to further their development and benefit patient care.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with other services

There was evidence of working with other services. This included working with the multidisciplinary team at the CCT meeting to discuss vulnerable patients, meetings with

Good

Are services effective?

(for example, treatment is effective)

palliative care and hospice care staff and individual communication with other health care professionals. This included physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Communication systems had been set up to allow the Out of Hours service GPs to access patient records, with their consent, using a local computer system. GPs were informed when patients were discharged from hospital. This prompted any medicine reviews that were needed.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP. Feedback from the comment cards showed that patients had different treatment options discussed with them.

The practice used a variety of ways of recording patients gave consent depending on the procedure. We saw evidence of patient consent for procedures including immunisations and injections.

Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the GPs had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. We were given specific examples by the GPs where they had been involved in best interest decisions.

Health Promotion & Prevention

There were specific clinics held for patients with complex illnesses and diseases. This was used as an opportunity to discuss lifestyle, diet and weight management. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered.

Any patient with a learning disability were offered a physical health check each year.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services. These prompts were also communicated at the QOF monitoring meetings.

There were a range of leaflets and information documents available for patients within the practice and on the website via a link to NHS Choices. These included information on family health, travel advice, long term conditions and minor illnesses. These website links were simple to locate.

Family planning, contraception and sexual health screening was provided at the practice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 20 completed cards which contained detailed positive comments. All comment cards contained some comment about the caring attitude of the staff.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues. Reception staff were familiar with the need for confidentiality and explained that they dissuaded patients from giving them details about their medical condition. The reception area was conducive to promoting privacy minimising the risk that conversations might be overheard in the waiting room.

Conversations between patients and clinical staff were confidential and always conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with curtains to maintain privacy and dignity.

A chaperone service was provided and there were posters in the waiting room for patients to read about it.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment was carried out. A chaperone is a member of staff or person who is present with a patient and a medical practitioner during a medical examination or treatment. A nurse or health care assistant was the usual member of staff called upon to be a chaperone although administration staff at the practice acted as chaperones as required following training. All staff who acted as chaperones had been checked with the Disclosure and Barring Service (DBS). They understood their role was to reassure and observe that interactions between patients and GPs were appropriate.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred, in their comments, to an on-going dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and on-going care arranged by practice staff.

Care plans for patients with complex decisions were detailed and person centre. Plans showed evidence of being agreed with the patient, with their views on self-management of their conditions so that a collaborate approach to symptom management could be agreed.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and the practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice had a nurse carers' champion who had undertaken training in this role. They identified carers and met regularly with them to discuss their own health, emotional and support needs.

Staff told us families who had suffered bereavement were contacted by their usual GP and a home visit or visits were offered to give emotional, physical health and social support advice. There was a counselling service available for patients to access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient. Some patients registered with the practice were living in registered nursing homes. A doctor visited these patients as requested by the care home. One of the GPs also visited regularly to review patients' medicines. This was confirmed by the GP during our conversation.

Systems were in place to ensure any patient who needed referral, including urgent referrals, for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that their referral to hospital consultants or for screening tests had always been discussed with them and arranged in a timely way.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other. Results were reviewed within 24 hours, or 48 hours if test results were routine. We found no backlog of test results waiting to be read and acted upon.

The practice had a patient participation group (PPG) in place. They held regular meetings with the practice manager and told us they found the practice responsive and keen to hear patient's views. Annual patient satisfaction surveys were carried out and results were posted on the practice website. The 2013 - 2014 results showed high satisfaction with services amongst patients and an action plan from the practice responding to comments to how services could be further improved for patients.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

There was level access to the entrance of the practice and the consulting rooms were also on the ground floor. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users.

We saw no evidence of discrimination when making care and treatment decisions.

However, there was no system in place for providing compliance aids for patients who needed help to take their medicines correctly. Staff told us that if this was needed patients would need to have their medicines dispensed at a pharmacy.

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

Information about the appointment times were found on the practice website and within the practice. Patients were informed of the out of hours arrangements when the practice was closed by a poster displayed in the practice, on the website and on the telephone answering message.

Although there was no formal system in place for delivering medicines to people who were house bound or unable to collect their own medicines staff told us if there was a problem on some occasions a member of staff had delivered medicines.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Patients told us they had no complaints and could not imagine needing to complain. Patients were aware of how to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also contained clear information on how patients could make a complaint.

Records were kept of complaints which showed that responses and investigations were timely and completed to the satisfaction of the patient. The practice reported receiving one complaint in the last 12 months. Records included evidence of any learning or actions taken following complaints. We saw action taken included meeting with people who raised a concern to resolve their dispute.

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

GPs and other members of staff talked of future plans, succession planning and changes in the business. This was kept under review in a structured way during the monthly management meetings. For example, it was anticipated that the patient list would continue to grow in the next 5 years and informal discussions had commenced regarding staffing capacity and plans for staff recruitment/ additional training and/or specialisation.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Any clinical incidents or issues were discussed amongst staff as they arose. For example, incidents were often addressed immediately and communicated through a process of face to face discussions and email. These issues were then followed up more formally at the general staff meetings.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Church View Medical Centre were consistently above the national average and compared well with the local clinical commissioning group (CCG). The practice had a patient list that was significantly higher than both the national and local CCG average for people aged 65 years and older. The practice was able to show it was both anticipatory and responsive when providing health services for this significant group of patients.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed, for example minor surgery and falls risk audits. Audits were thorough and followed a complete audit cycle.

Leadership, openness and transparency

There was a stable staff group. Many staff had worked at the practice for many years and were positive about the open culture within the practice. Nursing and administration staff spoke positively about the communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. GPs said there was support for each other when it was identified as being needed.

Staff told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings. Minutes from staff meetings were circulated. The practice also produced a newsletter for patients, to give them information about practice services and healthy lifestyle advice.

Management lead through learning & improvement

There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental assessments for the building. For example electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been maintained. Fire safety checks had been completed and fire alarms were checked weekly either during the lunch hour or before surgery so as not to disrupt patient consultations. A fire drill had been carried out in the last year and staff spoken to were familiar with their role if the situation arose.