Thornhills Medical Practice

Quality Report

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Date of inspection visit: 19 May 2014
Date of publication: 20/08/2014

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

Summary of findings

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Summary of findings

Overall summary

Thornhills Medical Practice provides primary medical services Monday to Fridays for patients in the Aylesford and surrounding areas in Kent. The practice has nine general practitioners (GPs), seven of whom form the partnership management team. The senior partner is the registered provider of services at the practice.

We spoke with patients during our inspection and over the phone the following day. They were all complimentary about the services they had received from the practice. No completed comment cards were received during our inspection but following our inspection two completed comment cards were sent to us. Patients we spoke with expressed a high level of satisfaction with the practice and the staff. We also met with three members of the Patient Reference Group (PRG), who emphasised the support, engagement and good working relationship the group had with the GP partners and staff at the practice. Staff we spoke with told us that the management were very open and approachable.

We found the practice was well-led and provided caring, effective and responsive services to a wide range of patient groups.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The practice demonstrated that changes had been made when things had gone wrong. Information about incidents had been shared amongst the team and measures had been put in place to reduce the risk of re-occurrence. There were safeguarding systems in place and all staff were trained to recognise the signs of abuse and what to do if abuse was suspected. The practice was not clean in certain areas but systems had been put in place to rectify this. We were provided with evidence following our inspection of how cleanliness would be maintained. Systems were in place to protect patients against the risks associated with medicines. Staff were trained and equipped to deal with medical emergencies.

Are services effective?

The practice was effective. There were enough suitably trained and experienced staff to meet the needs of the patients who used the practice. We saw evidence that the practice worked well with other healthcare providers and held and participated in a number of multidisciplinary meetings with other health and social care professionals, a care home and the local pharmacy. We saw a varied selection of information that was supplied to patients or was on display in the waiting area this included information on health promotion, prevention and travel advice.

Are services caring?

The practice was caring. Patients told us that they were always treated with dignity and respect by staff at the practice. We heard how compassionate the GPs were with regard to end of life care and how they had supported patients through bereavement. Patients commented on how they were involved in their care and had their options explained to them where this was possible. Staff we spoke with were able to demonstrate their understanding of the consent process.

Are services responsive to people's needs?

The practice was responsive to patients needs. There were systems and processes in place to respond and take action in response to unforeseeable events. The practice had a complaints procedure and complaints had been responded to in a timely manner. Patients were able to make suggestions to improve the services they received. Patients had been listened to and we saw that actions had been taken as a result of their comments and feedback.

Summary of findings

Are services well-led?

The practice was well-led. The management team provided structured leadership for staff. Staff told us that there was an open and supportive culture. They said they were comfortable approaching the senior and other partners for anything they needed, and management listened to them. There were monitoring and risk management systems in place that ensured lessons were learned and the service improved as a result.

Summary of findings

The six population groups and what we found

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

Older people

The practice had a higher than the national average population of older patients. We saw that the practice offered relevant care to older patients, this included blood tests, blood pressure monitoring, counselling and general well man/woman consultations.

Older patients were seen annually, or sooner depending on the complexity of their needs, by the nursing or medical team to review their medicines. The practice also held clinics for patients on medication for rheumatoid arthritis and blood clotting problems. Continued monitoring ensured that older patients received the right treatment and care when they needed it.

We saw that flu vaccinations were routinely offered to older patients to help protect them against the virus and associated illness. We saw that shingles vaccination was offered to patients over the age of 75 to help protect them against the virus.

We found the practice to be caring in the support it offered to older patients and there were effective treatments and ongoing support for those patients identified with dementia. The practice was responsive in meeting the needs of the older patients and in recognising future demand on the practice for this age group The practice was well led in relation to improving the provision of the service for patients and their families who were receiving end of life care.

The practice was responsive in meeting the needs of older people and in recognising future demands in service provision for this age group. The practice was well-led in relation to identifying a named lead GP trained in specialist dementia care and in recognising symptoms to enable early detection. There was a clear understanding from the leadership team of what the future of general practice would be and the practice had responded to it proactively.

People with long-term conditions

The practice offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, counselling, electro cardiography (ECG) and spirometry (to measure breathing) at the surgery. The practice offered nurse led chronic pulmonary obstructive disease (COPD), asthma and diabetes clinics and patients were seen at least annually for health checks.

Summary of findings

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illness were seen annually or sooner depending on the complexity, by the nursing or medical team to review their medicines. The practice also held daily clinics for patients on medication for rheumatoid arthritis, blood clotting asthma, chronic pulmonary disorder (COPD). Patients with long term conditions were appropriately monitored and medication could be monitored to ensure their wellbeing.

Staff from the local hospice attended meetings with the GPs and the nursing staff, this enabled GPs to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed of the care arrangements if emergencies or crises arose. To ensure that these patients received the care relevant to their circumstances regardless of when they needed it.

We found the practice to be caring in the support it offered to patients with long term conditions that the care they received was effective and treatment pathways were monitored and kept under review by a multidisciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in terms of improving outcomes for patients with long term conditions and complex needs

Mothers, babies, children and young people

The practice had a higher than the national average population of people under the age of 18 years. Mothers, babies, children and young people received relevant care from the practice. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife. Mothers were seen routinely for a postnatal check at the six to eight week stage. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations.

The practice worked closely with both the midwives and health visitors.

The practice offered on site blood tests and counselling services to mothers and young people.

We found that the practice was caring in its approach to mothers, babies, children and young people and provided effective services and treatment, offering dedicated clinics at the practice and referrals into community based services to provide additional

Summary of findings

support. The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice was well-led in relation to having a named lead with responsibility for children's safeguarding.

The working-age population and those recently retired

The working age population and those recently retired were offered relevant care by the practice. The practice held a telephone triage service every week day this was in addition to patients attending for appointments. The practice opened earlier and held later clinics each day Mondays to Thursdays so that patients had the opportunity to attend before or after work.

The practice offered on site blood tests, blood pressure monitoring, general well mans and woman consultations and counselling services to working age people

We saw that flu vaccinations were routinely offered to the working age population and those recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and travel advice on a private basis.

We found the practice to be caring in the support it offered to working age and recently retired patients, and were responsive by extending opening hours to provide access for patients later in the day. There were effective monitoring services and clinics and the management team completed clinical audit cycles to evaluate outcomes for patients in this group.

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

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care. The practice served a community of traveller families and they were frequent users of the practice. The practice also had patients who were homeless and had systems for keeping in touch with these patients so that they had access when they needed it even if they had moved out of the area.

We saw that flu vaccinations were routinely offered to patients who were in vulnerable circumstances to help protect them against the virus and associated illness.

The practice offered on site blood tests and counselling services to vulnerable people.

Summary of findings

We found that the practice was caring about vulnerable patients, the homeless and travelers, by providing access and support when there were issues around literacy. There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in people's homes who found it difficult to attend.

People experiencing poor mental health

We saw that the practice offered relevant care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments and where possible every effort was made to make appointments with the same GP.

Patients experiencing mental health problems had support from the practice, in the community and care and treatment when they needed it. The practice held multidisciplinary meetings bi-monthly which were attended by staff in the mental health team where they discussed arrangements for individual patients and ensured the out of hours service was informed of the care arrangements if emergencies or crises arose.

We found that the practice was caring in relation to patients experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments. The practice was responsive in referring patients to other service providers for on going support. We found the practice to be well-led with their approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Summary of findings

What people who use the service say

All of the patients we spoke with on the day of our inspection and over the telephone the following day were very positive about the services they had received at Thornhills Medical Practice. They were particularly complimentary about the staff, and said that they were always caring, supportive and sensitive to their needs. Patients told us that they felt safe when visiting the practice or when the GPs visited them in their homes.

Patients indicated that they had no concerns with regard to hygiene and the cleanliness of the practice. They told us that staff always washed their hands when examining them or carrying out a procedure.

We heard how patients felt they were involved in their care and treatment and that options were always explained and discussed with them. They told us that the staff always gave them enough information to be able to make decisions with regard to their care and that they could make these decisions in their own time.

Patients said that they were treated with dignity and respect when using the service and that they could request to speak to one of the reception staff or the patient co-ordinator privately if they wished.

Patients we spoke with told us that it was sometimes difficult to get an appointment with the same GP and this had been reflected in the most recent patient satisfaction survey. However, they said that this was improving.

We did not receive any comments from patients on the comment cards we sent the practice prior to our inspection. We received two comment cards following our inspection which had been sent to our customer centre. The comments received stated that reception staff had been rude and unhelpful and a complaint had been made through the practice complaints procedure but no response had been received with regard to the complaints made. We spoke with five members of the Patient Reference Group (PRG) who emphasised the support, engagement and working relationship they had with the management team

Areas for improvement

Action the service COULD take to improve

- Staff were not aware of when to report any allegation of abuse to the Care Quality Commission.
- No checks via the Disclosure and Barring Service (DBS) or risk assessments had been undertaken for reception or administration staff whose duties include chaperoning.
- we found that clinical waste was being handled and transported by the staff employed to clean the premises. There was no record that these members of staff had received the necessary vaccinations or training to handle and transport clinical waste safely.
- Non controlled medicines kept and used within the practice were not appropriately recorded or monitored to provide an accurate audit trail account of what had been issued, what had been used and the stocks remaining.

Thornhills Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP and the team included a specialist advisor who was a practice manager.

Background to Thornhills Medical Practice

Thornhills Medical Practice provides general medical services at the following location:

Larkfield Health Centre

Martin Square, Larkfield

Aylesford

Kent

ME20 6QJ

The practice has a higher than average population of patients over the age of 65 and young people under that age of 18.

Thornhills Medical Practice provides primary medical services Mondays to Fridays for patients in the Aylesford area in Kent. The practice provides a service for approximately 14500 patients.

Health care clinics are offered at the practice, led and provided by the clinical team. There are a range of population groups that use the practice, mostly comprising of older people, working age people and recently retired people and mothers, babies, children and young people.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before our visit to Thornhills Medical Practice, we reviewed a range of information we hold about the practice. This included information about the patient population groups, results of surveys and data from The Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP

Detailed findings

practices are financially rewarded for implementing and maintaining "good practice" in their surgeries. We asked other organisations to share what they knew about the practice this included the Local Commissioning Group and local Healthwatch.

We carried out an announced visit on 19 May 2014. Prior to our visit we provided comment cards for the practice to place in their waiting area so that patients could share their views and experiences of using the practice. During our visit we spoke with a range of staff which comprised of two GP partners, a registered nurse, one healthcare assistant, the deputy practice manager, the patient services supervisor, two administration staff and spoke with patients who used the practice. Following our inspection we spoke to patients over the telephone and asked for some information to be sent to us by email which we received. We observed how people were being cared for and talked with carers and family members and reviewed some practice records, policies and protocols.

Are services safe?

Summary of findings

The practice was safe. The practice could demonstrate that changes had been made when things had gone wrong. The information about incidents had been shared amongst the team and measures had been put into place to reduce the risk of re-occurrence. The practice in some areas was not clean, but generally tidy and hygienic. There were safeguarding systems in place and all staff were trained to recognise the signs of abuse and what to do if abuse was suspected. The provider showed us evidence that assured us the practice protected patients against the risks associated with medicines. The staff were trained and equipped to deal with medical emergencies.

Our findings

Safe patient care

New patients who registered with the practice completed a health questionnaire which provided important information about their past medical history, current health concerns and lifestyle choices. The practice offered new patients a consultation with a nurse or GP so that their individual needs were assessed and access to support and treatment was available as soon as possible. Patients notes were requested from their previous GP and relevant information was scanned into their electronic record.

Staff explained to us how the practice had electronic records in place to accurately describe the contact patients had with the practice and the actions taken to provide appropriate care and treatment. This included a record of patients test results and referral letters. The systems the practice had in place to ensure that patients health care was monitored following a particular diagnosis or hospital discharge were explained to us and demonstrated that patients had received after care and treatment or referrals to other health care professionals in a timely and appropriate way.

Learning from incidents

Systems were in place to report, record and analyse significant events with outcomes being shared at practice meetings. We looked at all of the significant events recorded this year, there were five in total. All were recorded and included detailed information regarding each event, the follow up action that was taken and the changes that were made as a result. For example, a locum GP had taken a prescription pad and had issued prescriptions whilst working at another practice. The practice contacted the locum who returned the prescription pad immediately. The practice held a significant events meeting and it was decided that locum GPs would only be issued with enough prescription for immediate surgery sessions only. Other significant events had been completed and we saw that the practice had made positive changes as a result of significant events. This demonstrated that the practice made changes to reduce risks of reoccurrence as a result of significant events.

Safeguarding

Patients we spoke with told us that they felt safe when visiting the practice or when they had a home visit. They told us that if they had any concerns they would speak to

the practice manager or directly to their GP. The practice offered a chaperone option where a member of staff would be available to escort people during intimate examinations at their request. We saw notices in the waiting area and in consultation rooms to that effect. All of the clinical staff had recently completed safeguarding training that was appropriate to their role. Staff we spoke with were aware of their responsibilities with regard to identifying and reporting any concerns about abuse. They were able to give examples of the types and signs of abuse and knew who to report any concerns to including the local authority reporting procedures. Staff were not completely familiar with the practice's safeguarding policy and but knew where to locate it. We brought this to the attention of the registered manager, who following our inspection provided evidence that the practice safeguarding policy and procedures had been circulated to all staff to refresh their knowledge.

Medicines management

The practice had a named prescribing lead, who was responsible for the management of medicines. We spoke with a member of the clinical team who told us that the practice had a system for checking that repeat prescriptions were issued according to the medicine review date for each patient. This was to ensure that patients on long-term medication were seen and their medicines reviewed on a regular basis. We saw that the practice had a prescription security policy that set out how prescription were issued to clinicians. The policy indicated who was responsible for monitoring prescription pad stocks and records showed the individual prescription pad numbers issued and in use within the practice. We found that prescription forms were not always stored in line with the practice prescription policy. We found that blank prescriptions were in a box in an unlocked room and not kept in a locked cupboard as the prescription policy stated. We brought this to the attention of the registered manager who removed and secured the prescription forms immediately. Following our inspection the registered manager provided us with evidence of how this would be maintained and to ensure us that staff were adhering to the policy and all prescription forms and pads were locked away when not in use and at the end of each clinical session.

We looked at the medicines and equipment kept on the emergency response trolley and found that whilst the medicines were within usable date, records were not kept to identify the stocks held. We checked the emergency medicines kept in a doctor's bag and found that checks were not undertaken to monitor and record the medicines held. Therefore emergency medicines kept and used within the practice were not appropriately recorded or monitored to provide an accurate audit trail account of what had been issued, what had been used and the stocks remaining. Following our inspection the registered manager provided us with evidence that ensured us that medicine stocks had been recorded and a system implemented to monitor medicine stocks within the practice.

We saw that the practice had in place and followed guidelines for maintaining the vaccine cold chain (The vaccine cold chain is system that controls the transportation and storage of vaccine medicines within a safe temperature range) so that the viability of vaccinations could be assured. Staff explained to us how the vaccines were kept in line with the manufacturers' recommendations. The vaccines were kept in a locked fridge which was located in the nurse's consultation room. We saw that staff were routinely monitoring and recording the fridge temperature to ensure that it was operating within a safe range. The fridge temperature was recorded daily on a calendar with the exception of weekends when the practice was closed. Staff told us that the fridge would set off an alarm if the temperature was out of the safe range or if it failed at night or over a weekend. They told us of the local protocol for seeking advice from the relevant manufacturers to determine whether the vaccines required replacement if they had been exposed to non-standard temperatures.

Cleanliness and infection control

During our inspection we visited patient waiting and treatment areas, administrative and office spaces. We found that the practice was generally visibly clean and tidy. There was hard flooring in the treatment and consultation rooms which was clean and intact. This enabled staff to clean any contamination or spillages effectively. However, in the minor operation suite we found that the area underneath the operating table was visibly dusty and had not been cleaned for some time. We brought this to the attention of the infection control lead also we found that there was a large collection of dust and debris along one of the privacy curtain rails in a nurse's consultation room. Staff assured us that a more robust cleaning schedule had been introduced so that all areas which included under the operating table and along curtain tracks would be cleaned

routinely from now on. The practice had fabric privacy curtains in the consultation and treatment rooms. There was no documentation to show when the curtains had been cleaned or when they needed to be changed. We spoke with the provider and the infection control lead about the infection control risks associated with fabric privacy curtains. Following our inspection the deputy manager provided us with an invoice to show that disposable privacy curtains had been ordered and a curtain change log had been implemented. The practice could show that the risks associated with the spread of infection had been minimised.

Each treatment and consultation room was stocked with personal protective equipment including a range of disposable gloves, aprons and coverings. This enabled the clinical staff to follow clean processes. We saw that there was a supply of antibacterial hand wash, and gel and paper towels available throughout the practice. Patients told us that the staff always washed their hands and the practice was always cleaned to a high standard. Patients told us that they had no concerns with regard to the cleanliness of the practice.

We saw that there was a system for handling, storing and disposing of clinical waste. However on the day of our visit we found that clinical waste was being handled and transported by the staff employed to clean the premises. There was no record that these members of staff had received the necessary vaccinations or training to handle and transport clinical waste safely. We brought this to the attention of the registered manager. Following our inspection the deputy manager provided us with training certificates and declarations to opt out of receiving certain vaccinations and that clinical waste was being handled, transported and stored safely.

Staffing and recruitment

Staff were recruited safely with the necessary checks being carried out on all of the clinical staff including locums. We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice had an effective recruitment policy, we found that some files did not contain sufficient information about the staff employed, for example, photographic identification (ID) as required by legislation. We brought this to the attention of the deputy manager who provided evidence to us following the inspection that ensured us that photographic ID was available for all members of staff employed at the practice.

No checks via the Disclosure and Barring Service (DBS) had been undertaken for reception or administration staff whose duties include chaperoning. No risk assessments had been undertaken with regard to non-clinical staff chaperoning patients. Following our inspection the deputy manager provided us with a revised Disclosure and Barring protocol and evidence to assure us that all staff would be DBS checked or risk assessed where required.

Dealing with Emergencies

The practice was prepared and could respond in the event of a patient suffering a medical emergency. Staff had received Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) training, we saw evidence that this had taken place. The practice had a supply of emergency medication which had been checked and were all in date. The oxygen cylinder and defibrillator had been regularly checked and was fit for purpose.

We looked at the practice fire policy and fire drill protocols. All of the staff we spoke with were aware of their roles and responsibility should a fire occur and we saw evidence that regular testing and checking of the alarm and fire equipment had taken place. To ensure that care would not be compromised and patients would have access to a GP at all times, we saw the practice had a comprehensive contingency plan in the event of a fire, flood, extreme weather and loss of utilities.

Equipment

We saw that staff had taken steps to protect patients against the risks associated with the equipment they used. We looked at evidence of appropriate maintenance of the equipment had been carried out, including electrical checks and calibration of clinical apparatus such as the blood pressure monitor and nebuliser. All had been checked, tested and passed as fit for purpose. This demonstrated that staff had taken steps to protect patients against the risks associated with the equipment they used.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. There were enough suitably trained and experienced staff to meet the needs of the patients who used the practice. We saw evidence that the practice worked very well with other healthcare providers. We found that they held and participated in a number of multidisciplinary meetings with other health and social care professionals, a care home and the local pharmacy. We saw a varied selection of information that was supplied to patients or on display in the waiting area this included information on health promotion, prevention and travel advice.

Our findings

Management Monitoring & Improving Outcomes for People.

The practice had participated in the annual national Quality and Outcomes Framework (QOF). The QOF is a nationally recognised programme for GP surgeries in England. The practice is required to achieve targets for each domain. These domains include care such as coronary heart disease, high blood pressure, diabetes and asthma. The practice used this system to monitor, improve and maintain the services they provided under each domain. The results of the 2013 QOF had resulted in changes to services being provided, such as the re-call system for health reviews and diabetes checks. The practice used the results to improve services for their patients and had plans in place to re-audit to ensure that the changes led to improvements.

Staffing

We found that there were enough staff available to cover the needs of the patients using the practice. The practice provided enough clinical sessions which were above the national average required for the patient population who had access to the practice. Patients had their health and welfare needs met by sufficient numbers of appropriate staff with the right knowledge, skills, experience and qualifications to support their needs.

Working with other services

Patients health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. The practice had protocols and systems in place for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. Regular multidisciplinary meetings took place between clinical staff and staff at the practice, we looked at the minutes of these meetings. We saw that individual cases had been discussed and plans put in place to meet patients needs and keep them safe. The local hospice held meetings with the GPs and the nursing staff, this enabled the GP to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care

Are services effective?

(for example, treatment is effective)

plans, they ensured the out of hours service was informed of the care arrangements if emergencies or crisis arose duty GP. Patients had care and treatment and advanced decisions were upheld when using other services.

There were arrangements in place for sending referrals and receiving various test results and feedback from other health professionals. The staff we spoke with told us of the training they had received to enable them to audit and ensure that the system for results and referrals was working effectively. All test results were seen by a GP first, and then scanned into the patients records. Results were checked and arrangements made for patients in a timely manner.

Health, promotion and prevention

Patients were given appropriate information, support and advice regarding their care and treatment. We saw there were a range of information leaflets in the waiting area and posters detailing services provided by the practice and external clinics. Patients were given further written information, if needed to encourage independence, self-treatment, and advice regarding health promotion and support services such as smoking cessation and healthy living. We were shown a copy of the practice leaflet, this contained useful information for patients about the practice, including how to access GP support when the practice was closed. Patients were encouraged to treat minor ailments or injury and had information about when it would be necessary to attend the practice. The practice website held information and advice for patients that they could refer to, such as what to do and how to manage common ailments such as back pain and seasonal conditions such as flu.

Are services caring?

Summary of findings

The practice was caring. Patients told us that they were always treated with dignity and respect when using the practice. We heard how compassionate the GPs were with regard to end of life care and how they had supported patients through bereavement. Patients commented on how they were involved in their care and had their options explained to them where this was possible. Staff we spoke with were able to demonstrate their understanding of the consent process. However we found that some staff had not received Mental Capacity Act 2005 (MCA) training.

Our findings

Respect, dignity, compassion and empathy

We observed that all staff spoke to patients in a friendly and helpful manner. All staff spoken with demonstrated a good understanding of how patients privacy and confidentiality was preserved. Reception staff explained how patients could request a private room to discuss anything they did not wish to discuss in the waiting area and this would be arranged. Patients we spoke with confirmed that they had requested to speak to staff in private and this was always arranged promptly. Consultation rooms had examination couches with surrounding privacy curtains and blinds at the windows that were used when consultations or treatments were undertaken. We noted that during a consultation the doors were closed and no conversations could be overheard in the corridor outside. Staff were able to explain how they would preserve a patients dignity when carrying out intimate examinations. Patients were also able to request a chaperone should they wish and details regarding the chaperone service were displayed in all of the consultation rooms and the waiting area. Patients told us that when they attended the practice, staff were always caring and happy to spend time with them as they needed.

Involvement in decisions and consent

The practice routinely involved patients with their care and treatment and their choices were respected. Patients told us that they had time to discuss their concerns or treatments when they attended for appointments and that it was possible to book a double appointment when they needed to discuss more than one concern or complex problems. If a patient needed to be referred to another service or specialist this was discussed during their appointment and they were given a choice of location, where possible.

Staff we spoke with were able to demonstrate their understanding of consent and that patients had the right to withdraw it at any time and that this would be respected.

Where patients did not have the capacity to consent to treatment, staff could demonstrate that they acted in accordance with legal requirements. Mental capacity is the ability to make an informed decision based on understanding the options available and the consequences of decisions made. If patients were unable to make a decision for themselves staff told us that they would

Are services caring?

involve relatives to support patients in their treatment options. The practice had access to an advocacy service but to date had not had the necessity to use this. Therefore patients who were unable to make decisions for themselves were given appropriate support.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients needs. There were systems and processes in place to respond and take action when things did not go as planned. The practice had a complaints procedure and complaints had been responded to in a timely manner. Patients were able to make suggestions to improve the services they received, patients had been listened to and we saw that actions had been taken as a result of their comments and feedback.

Our findings

Responding to and meeting people's needs

42% of patients who had participated in the most recent patient survey had indicated frustration with having to see a different GP each time they visited the surgery. Patients we spoke with said that it was not always easy to see a preferred GP as the GPs worked part time. All did say, however, they had been seen quickly when needed but this meant that they would have to explain everything again with another GP.

We spoke with the registered manager about the concerns patients had with continuity. The registered manager explained that with a multitude of changes in staff there had been times where it was necessary to use locums, this had resulted in many changes of GPs at the practice. We saw that the practice had dealt with the concerns and responded to patients feedback about seeing the same GP.

With the new planned partnership arrangements, face to face meetings with patients was to be implemented which would strengthen relationships between patient and GPs with an emphasis on getting to know each other.

Access to the service

Patients had expressed their concerns with regard to getting appointments, the telephone system and seeing the same GP for continuity of care. Patients we spoke with indicated that it was sometimes difficult to get an appointment. They told us that when they had called they often received an automated message stating that the lines were busy and advising them to call back. When they did get through they found that there were no appointments available and were advised to call again the next day. Patients told us that this was sometimes frustrating. Patients we spoke with all commented that the appointment system had improved but there was still some difficulty at getting through on the telephone at the beginning of the day. Patients told us that generally they were able to get an appointment when they needed or speak to one of the GPs over the telephone. Patients said that in emergency or urgent situations they had not experienced any problems getting to see a GP promptly.

Concerns and complaints

The practice took steps to make patients aware of the complaints system. We saw there was information in the practice leaflet to alert patients to the comments and

Are services responsive to people's needs?

(for example, to feedback?)

complaints process. We looked at the practice complaints policy and procedures. The policy detailed the timescales for responding to any complaint received and the details of who to complain to if the patient was not satisfied with the response from the practice. This included reference to the Health Service Ombudsman. Staff we spoke with were aware of their responsibilities in the event of a complaint being received. We looked at the complaints the practice had received this year, we saw that the complaints procedure had been followed and that issues had been raised directly with the Concerned. Learning points had been shared with the clinical team and in the responses to the patients. Patients we spoke with said that they had not had any reasons to make a complaint. However they all told us that they were not aware of the complaints procedure but would speak to the practice manager or their GP if they were not happy with anything.

Are services well-led?

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

Summary of findings

The practice was well-led. The management team were in the process of developing a more structured leadership procedure for staff. Staff told us that there was an open and supportive culture, that they were comfortable approaching the senior and other partners for anything they needed and that management listened to them. There were monitoring and risk management systems in place that ensured that lessons were learned and the practice improved as a result.

Our findings

Leadership and culture

We spoke with management at the practice, who told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs were the providers at the practice, being equal partners, to promote shared responsibility in the working arrangements and commitment to the practice. Group lunches and social occasions were regularly held to promote a team ethos. The staff we spoke with told us that they felt there was an open door culture, that the GPs were visible and approachable, that they felt supported and were able to approach the senior staff about any concerns they had. They said that there was a good sense of team work within the practice and communication worked well. We saw that a named GP had a pastoral lead role in supporting the clinical team.

Governance arrangements

There were delegated responsibilities to named GPs, such as a lead for the safeguarding of vulnerable adults and children, a prescribing and clinical governance lead. This provided structure for staff and clear lines of who to contact for support and guidance when needed. Staff undertook clinical governance as part of their personal learning development and revalidation process. Staff told us of a medications dosing audit that had been carried out recently. The results of the audit had been shared via the practice computer system to other members of the clinical team. Each GP had completed clinical audits. We saw evidence of previous audits concerning a named medicine and dementia. The results had been shared during clinical meetings and had been used to check the standards of clinical services that patients had received. New processes were re-audited to ensure that the changes made improvements to patient care.

Systems to monitor and improve quality and improvement

During our visit we looked at a number of systems the practice had in place to assess the quality of the service it provided. The policies and procedures in place were available for staff to access which supported the safe running of the practice. All of the policies and procedures we examined were dated and reviewed on an annual basis or more frequently as required. The practice had a number

Are services well-led?

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

of systems to check and ensure the practice was effective and safe. For example we looked at audits carried out in relation to appointments and health and safety where improvements were required; the practice had taken action to resolve any issues.

Patient experience and involvement

The practice had systems in place to seek and act upon feedback from patients. The practice promoted a Patient Reference Group (PRG). The group was made up of practice staff and sixteen patients that represented the patient population. However, the PRG for Thornhills Medical Practice had been consistently trying to recruit younger people to join but had not been successful to date. We spoke with five members of the PRG during our visit and they were able to give us detailed and positive feedback about the practice. They told us that they felt listened to by the practice team and suggestions they made were acted upon.

We saw that the practice responded to issues or concerns raised by patients in a positive way. We looked at the most recent patient satisfaction survey carried out from December 2013 to January 2014 this survey had been amended to cover specific areas that had been discussed at the October 2013 PRG meeting. The areas covered were Out of Hours services, practice procedures and online services. The results of the survey were published on the website and the areas of concern raised were in the process of being reviewed and addressed by the practice.

Staff engagement and involvement

Staff were encouraged to attend and participate in regular staff meetings and we saw evidence that regular meetings took place which included discussions about changes to procedures, clinical practice and staff cover arrangements. We saw that the staff had a whistleblowing policy that included outside agencies for staff to contact if staff wished to report any concerns they had. Staff had a forum to highlight and discuss areas of their role that were going well and influence change when things were difficult.

Learning and improvement

We saw that general and individual issues and cases had been discussed at clinical meetings with learning points that had been considered and shared amongst the clinicians. The practice was designated as a learning practice where qualified doctors (registrars) trained to become GPs. Whilst at the practice they developed their knowledge, skills and clinical competencies. This was considered important to the practice in strengthening and supporting an exchange of learning and innovation amongst all clinicians. We saw that all staff at the practice had completed basic life support and the use of an automated external defibrillator (AED) and other courses such as safeguarding. We saw a training plan where other courses and were planned such as smoking cessation and the use of the practice software system. We noted from staff training records that some staff had not received Mental Capacity Act 2005 training. The practice responded to the learning needs of the staff and ensured that they attended relevant training to provide safe appropriate care to patients.

Identification and management of risk

We saw systems and processes were in place to manage risks. Risk assessments were used to consider individual risks to patients, staff and visitors to the practice. Assessments had been undertaken to consider and determine likely risks to patients, staff and visitors such as fire assessments and environmental hazards. Also disruption to the practice had been risk assessed such as continuity of the service in the event of disruption or loss of the premises.

Older people

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

Summary of findings

The practice had a higher than the national average population of older patients. We saw that the practice offered relevant care to older patients, this included blood tests, blood pressure monitoring, counselling and general well man/woman consultations.

Our findings

The practice provided annual flu vaccination clinics for older people, to provide ongoing protection/prevention from contracting the virus and associated complications/ illness.

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for vulnerable older people.

We found that the practice had systems in place to manage medicines safely and help protect older patients from the risks associated with medicines.

The practice had infection control procedures and systems in place to minimise the risks of cross infection for older patients.

We looked at some staff files and saw that appropriate safety checks had been carried out for all of the clinical team. The practice was in the process of obtaining safety checks for non-clinical staff that performed chaperoning duties and handled money and prescriptions. The practice had a robust recruitment policy for all staff including locums.

We found the practice to be caring in the support it offered to older patients. There were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia, diabetes and other illnesses. This enabled older patients to have continuity of care in supporting them with ongoing routine and more complex health care needs.

The practice had a system to identify patients who presented with symptoms that may indicate dementia. Follow-up blood tests would be arranged at the practice and a referral made to the specialist mental health nurse to carry out mental health assessments. Following diagnosis, the patient would be referred and linked to other support

Older people

services. Patients were also referred by the practice to groups and clinics that provide ongoing support and treatment for physical health care needs, including a foot care clinic.

The practice acknowledged that the patients they supported included a significant number of older people, who may place higher demands on the practice as an ageing population group in the future, with associated health care needs and complex conditions. The management had therefore considered how future planning would respond to the needs of patients in this age group and had taken some actions to address this, for example, additional specialist training in dementia and end of life care had been identified for the GPs.

We saw evidence that the practice undertook clinical audits to improve outcomes for older patients. The results were reviewed against national data to determine any changes that could be made to care/treatment pathways and clinical therapies to improve outcomes for older patients.

People with long term conditions

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

Summary of findings

The practice offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, counselling, electro cardiography (ECG) and spirometry (to measure breathing) at the surgery. The practice offered nurse led chronic pulmonary obstructive disease (COPD), asthma and diabetes clinics and patients were seen at least annually for health checks.

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illness were seen annually or sooner depending on the complexity, by the nursing or medical team to review their medicines. The practice also held daily clinics for patients on medication for rheumatoid arthritis, blood clotting asthma, chronic pulmonary disorder (COPD). Patients with long term conditions were appropriately monitored and medication could be monitored to ensure their wellbeing.

Staff from the local hospice attended meetings with the GPs and the nursing staff, this enabled GPs to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed of the care arrangements if emergencies or crises arose. To ensure that these patients received the care relevant to their circumstances regardless of when they needed it.

We found the practice to be caring in the support it offered to patients with long term conditions that the care they received was effective and treatment pathways were monitored and kept under review by a multidisciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in terms of improving outcomes for patients with long term conditions and complex needs.

People with long term conditions

Our findings

The practice provided annual flu vaccination clinics for patients with long term conditions, to provide ongoing protection/prevention from contracting the virus and associated complications/illness.

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable young people and adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for vulnerable adults.

We found that the practice had systems in place to manage medicines safely and help protect patients with long term conditions from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients with long term conditions.

We spoke with a number of patients who had long-term conditions and they were consistently positive about the care and support they received from the practice and the staff. They told us that their well-being was monitored and they were re-called for routine checks and follow-up appointments on a regular basis.

Patients with long-term conditions and complex needs were supported by the clinical nursing team at the practice, who provided specialist care and treatments for specific conditions and attended the weekly multi-disciplinary meetings at the practice. Patients with long-term conditions were monitored and their treatment pathways kept under review.

Patients we spoke with who had long-term conditions had told us that when they required an urgent appointment, the practice ensured they were prioritised and would be able to see a GP quickly.

We saw evidence that the practice undertook clinical audits to improve outcomes for patients with long-term conditions. The results were reviewed against national data to determine any changes that could be made to care/ treatment pathways and clinical therapies to improve outcomes for patients with long term conditions.

Mothers, babies, children and young people

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

Summary of findings

The practice had a higher than the national average population of people under the age of 18 years. Mothers, babies, children and young people received relevant care from the practice. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife. Mothers were seen routinely for a postnatal check at the six to eight week stage. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations.

The practice worked closely with both the midwives and health visitors.

The practice offered on site blood tests and counselling services to mothers and young people.

We found that the practice was caring in its approach to mothers, babies, children and young people and provided effective services and treatment, offering dedicated clinics at the practice and referrals into community based services to provide additional support. The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice was well-led in relation to having a named lead with responsibility for children's safeguarding.

Our findings

The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had systems in place to manage medicines safely and help protect mother's babies, children and young people from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for mothers, babies, children and young people.

We looked at some staff files and saw that appropriate safety checks had been carried out for all of the clinical team. The practice was in the process of obtaining safety checks for non-clinical staff that performed chaperoning duties and handled money and prescriptions. The practice had a robust recruitment policy for all staff including locums.

The practice supported the Patient Reference Group to engage with mothers who had babies, children and young people. They had been asked for their views, comments and suggestions during the most recent patient survey about the type of clinics, services and information they would like to see developed at the practice, for example, maternity issues, childhood illness and immunisation, sexual health clinics and alcohol advice.

The practice had links and routinely made referrals for mothers with babies and young children to the community health visitor, providing an additional level of support. The practice also offered regular baby and child immunisation clinics, and ante/post-natal clinics provided by the clinical team. They also referred young people to the appropriate service for care and advice if required.

Mothers, babies, children and young people

Sometimes patients experienced extended waiting times in the reception/waiting area. Comments had been received from mothers and other patients, who felt that it was not appropriate for babies and young children to be kept waiting and the practice had subsequently introduced a system to alert the GPs when babies and/or young children were waiting to be seen. GPs were then able to prioritise appointments around these patients. The practice offered services and advised young people with regard to healthy living, sexual health and alcohol advice.

The management at the practice had identified a named lead for safeguarding children who had specific responsibility for disseminating information and training to other staff within the practice.

Working age people (and those recently retired)

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

Summary of findings

The working age population and those recently retired were offered relevant care by the practice. The practice held a telephone triage service every week day this was in addition to patients attending for appointments. The practice opened earlier and held later clinics each day Mondays to Thursdays so that patients had the opportunity to attend before or after work.

The practice offered on site blood tests, blood pressure monitoring, general well mans and woman consultations and counselling services to working age people

We saw that flu vaccinations were routinely offered to the working age population and those recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and travel advice on a private basis.

We found the practice to be caring in the support it offered to working age and recently retired patients, and were responsive by extending opening hours to provide access for patients later in the day. There were effective monitoring services and clinics and the management team completed clinical audit cycles to evaluate outcomes for patients in this group.

Our findings

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for vulnerable adults.

We found that the practice had systems in place to manage medicines safely and help protect working age patients from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for working age patients.

The practice supported the Patient Reference Group to engage with working age patients. They had been asked for their views, comments and suggestions in the most recent patient survey about the type of clinics, services and information they would like to see developed at the practice, for example, online services development.

The practice offered a range of services and clinics to provide monitoring and routine support for patients in this age group, including lifestyle and healthy living checks, blood pressure and diabetes checks.

The practice had introduced extended opening hours and surgery times for working age patients who may find it difficult to attend appointments during core working hours. This included some early week-day mornings and evenings.

The practice management team had systems in place to ensure clinical audit cycles were completed to highlight/ identify where improvements could potentially be made for working age patients.

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

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

Summary of findings

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care. The practice served a community of traveller families and they were frequent users of the practice. The practice also had patients who were homeless and had systems for keeping in touch with these patients so that they had access when they needed it even if they had moved out of the area.

We saw that flu vaccinations were routinely offered to patients who were in vulnerable circumstances to help protect them against the virus and associated illness.

The practice offered on site blood tests and counselling services to vulnerable people.

We found that the practice was caring about vulnerable patients, the homeless and travellers, by providing access and support when there were issues around literacy. There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in people's homes who found it difficult to attend.

Our findings

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had systems in place to manage medicines safely and help protect vulnerable patients from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for vulnerable patients.

We looked at some staff files and saw that appropriate safety checks had been carried out for all of the clinical team. The practice was in the process of obtaining safety checks for non-clinical staff that performed chaperoning duties and handled money and prescriptions. The practice had a robust recruitment policy for all staff including locums.

We saw that flu vaccinations were routinely offered to patients who were in vulnerable circumstances who may have poor access to a GP to help protect them against the virus and associated illness.

We observed that the premises enabled easy access for patients with reduced mobility. Special arrangements were made to see patients with mobility problems in a downstairs consultation room.

The practice provided routine care to patients in vulnerable circumstances who may have poor access to primary care. The practice had patients who were homeless and had systems in place for keeping in touch with these patients.

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

One of the GPs would ring vulnerable patients to check that they were ok and offer help and support if required. This meant that they had access when they needed it even if they had moved out of the area.

The practice recognised that some vulnerable patients may find it difficult to attend the GPs surgery for care and treatment. We were told that the GP or the district nurse would support and treat patients at home if they were housebound, enabling patients with limited access and mobility to receive appropriate care and treatment in their homes. There was access to translation services to patients whose first language was not English.

The practice recognised and acknowledged that the practice had few identifiable vulnerable patient groups within the locality of the practice. However, where patients were identified as particularly vulnerable, mechanisms had been put in place to help ensure equality of access to the practice and the services provided.

People experiencing poor mental health

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

Summary of findings

We saw that the practice offered relevant care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments and where possible every effort was made to make appointments with the same GP.

Patients experiencing mental health problems had support from the practice, in the community and care and treatment when they needed it. The practice held multidisciplinary meetings bi-monthly which were attended by staff in the mental health team where they discussed arrangements for individual patients and ensured the out of hours service was informed of the care arrangements if emergencies or crises arose.

We found that the practice was caring in relation to patients experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments. The practice was responsive in referring patients to other service providers for ongoing support. We found the practice to be well-led with their approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Our findings

The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. This meant that staff were able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had systems in place to manage medicines safely and help protect patients experiencing poor mental health from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients experiencing poor mental health.

We looked at some staff files and saw that appropriate safety checks had been carried out for all of the clinical team. The practice was in the process of obtaining safety checks for non-clinical staff that performed chaperoning duties and handled money and prescriptions. The practice had a robust recruitment policy for all staff including locums.

We saw that flu vaccinations were routinely offered to patients experiencing poor mental health to help protect them against the virus and associated illness.

We saw that the practice offered relevant care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments and where possible every effort was made to make appointments with the same GP.

We were told by staff that the practice undertook mental health assessments as part of other routine health checks. This helped to identify mental health issues and early detection for patients who would then be referred to specialist services and receive ongoing support.

The practice held multidisciplinary meetings to consider individual patients needs, including those who may be

People experiencing poor mental health

experiencing mental health issues. If concerns were indicated, a referral was made to the specialist mental health nurse, who would provide appropriate support/ interventions.

The management team had systems and procedures in place to identify and manage risks to individual patients which included those who presented with poor mental health.