Sterling 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

We carried out an announced comprehensive inspection at Stirling Medical Centre on 21 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing the capacity of patients 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. The practice had developed robust supervision and support for all staff which included weekly and monthly reviews with the manager. Staff worked effectively with multidisciplinary teams and agencies.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally found it easy to make an appointment. Urgent appointments were available the same day. The practice had a range of 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular staff meetings. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice promoted a patient survey including friends and family test which patients were encouraged to complete on attendance at the practice. The patient participation group (PPG) was currently being re-introduced. Staff had received inductions, regular performance reviews and attended staff meetings and training 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

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and regular review took place for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients in this group had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP and or specialist nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in-line with CCG averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered 'together appointments' and had regular communication between health visitors, school nurses and safeguarding teams as appropriate.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering

Summary of findings

easily accessible appointment system and telephone triage. We saw that the practice provided a range of services patients could access at times that best suited them or close to their work by accessing an appointment in another branch of the practice.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had good open communication links with veterans outreach service 'open minds'. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It also carried out advance care planning for patients with dementia.

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

Summary of findings

What people who use the service say

We received 31 completed CQC comment cards from patients, of which, all were positive about their experience using the services provided. We spoke with five patients on the day of our inspection. All patients we spoke with were complimentary about the care they received from the GPs and felt that staff treat them with dignity, compassion and respect.

We spoke with specific patient groups and they were able to tell us of their experiences, in particular older people and people with long term conditions. The majority of patients had been registered patients of the practice for a number of years. They were all very happy with the services the practice provided.

Patients told us this practice was a small family run practice, they were the most supportive, caring and helpful practice they had been to and they would never use anyone else. They said they felt they were always given enough time during their appointment and spoke highly of the GPs. As the practice provided care and support mainly for the older population, the staff could easily relate to patients as they were long-standing patients and were well known to all staff. We saw this in practice as part of our observations.

We saw that the practice was continually seeking feedback from patients to shape and develop services in the future. Patient views were listened too and the results of national patient's survey reviewed quarterly. The latest review of the national GP survey results for 2014 identified that 365 surveys had been sent to patients between January and September 2014. 75% commented that their GP was good at involving them in decisions about their care whilst 94% commented they had to wait 15 mins or less for their appointment. 85% of patients commented that their GP was good at explaining tests and treatments.

Sterling Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Sterling Medical Centre

The practice delivers primary care under a Personal Medical Services (PMS) Contract between themselves and NHS England for patients living in Grimsby, Cleethorpes and surrounding areas. The practice has two GP partners, who are both male. They are part of the NHS North East Lincolnshire Clinical Commissioning Group (CCG). There are approximately 2,300 patients registered at Stirling Medical Centre.

The practice opening times are from Monday to Friday 09.30am – 17.00pm. In addition, there are extended hours appointments available on Wednesday evenings to 18.30pm. There are no Saturday appointments available at Stirling Medical Centre. Early appointments are available at the practice branch New Waltham Surgery from 08.00am to 12.30pm. The practice does not provide an out-of-hours service to their own patients directly and patients are automatically diverted to the local out-of-hours service Prime care when the surgery is closed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This provider had not been inspected before 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

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 had poor access to primary care
- People experiencing a mental health problems

Before visiting Stirling Medical Centre, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We asked NHS North East Lincolnshire Clinical Commissioning Group (CCG). and the Local Healthwatch to tell us what they knew about the practice and the service provided. We asked the surgery to provide a range of

Detailed findings

policies and procedures and other relevant information before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection visit on 21st January 2015. During our inspection we spoke with a range of staff including GPs, a practice nurse, practice manager and administration and reception staff. We spoke with five patients who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed 31 CQC comment cards where patients and members of the public shared their views and experiences about the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor patient safety and had a good track record for maintaining patient safety. We looked at the significant events analysis over the last year and saw that there were three separate events identified.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Our discussion with GPs, nurses and non-clinical staff showed that they were aware and fully involved in safe practices and protocols. Staff told us that a significant events analysis (SEA) discussion took place at regular meetings and one to one sessions.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. We saw that any significant event had been recorded and there were documented details of the event, how learning was implemented and actions taken to reduce the risk of them happening again.

The practice manager showed us the system used to manage and monitor incidents. We saw that incidents were completed in a comprehensive and timely way. We saw evidence of action taken as a result (where a patient referral letter was not fully acknowledged by the GP before sending it). Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were communicated via computer alerts and paper bulletins to practice staff. We saw that alerts were cascaded within the practice team, to ensure that staff were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. The practice nurse had implemented a frequent A&E attenders system to review patient information and these were followed up by a named nurse to reduce further admissions in the future.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The GP was appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The practice had up to date medicines management policies and prescribing protocols in place. We saw that medicines for use in the practice were stored securely and only clinical staff had access to them. GP bags were regularly checked to ensure that the contents were intact and in date. There were processes in place to ensure that stocks of medicines such as vaccines were readily available, in date and ready to use. We looked at how vaccines were ordered and saw that they were checked on receipt and stored appropriately in accordance with the manufactures recommendations.

Some medicines were stored in a lockable fridge and staff recorded the temperature daily to ensure medicines were stored in line with manufacturer's recommendations.

Staff were able to demonstrate the process and audit trail for the authorisation and review of repeat prescriptions. Prescription pads and repeat prescriptions were stored securely.

Cleanliness and infection control

We observed all areas of the practice to be clean and tidy. The practice had an infection prevention and control policy (IPC). Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nominated infection control lead who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead had carried out IPC audits and that any improvements identified for action were completed on time.

Fabric curtains were used in consulting and treatment rooms, which were clean and free from marks or malodours. There were arrangements in place for the collection of general and clinical waste. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us there was enough equipment in place to meet the needs of the practice. We saw that equipment checks were regularly carried out and staff were aware of who to report maintenance issues or faults to.

There were processes in place to regularly check and calibrate equipment used in clinical areas. We saw records showing that equipment had been serviced and maintained at required intervals and to the manufacturers recommendations. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

We saw that annual checks on portable appliance electrical (PAT) testing equipment had taken place and servicing arrangements were in place; for example weighing scales, spirometers, blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy and process in place. We looked at four staff files and appropriate checks were carried out before the staff member began working within the practice. Staff had a recent Disclosure and Barring Service check (DBS) in line with the recruitment policy. We saw that there was an appropriate level of skill mix of staff in the practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Good

Are services safe?

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records that demonstrated staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was available to staff on the practice computer system.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GP and nurse were allocated lead roles or areas of responsibility, for example safeguarding and infection control. Procedures were in place to assess, manage and monitor risks to patient and staff safety, which included fire risk assessments and monthly health and safety/environment checks.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, patient areas and risk assessments for the health and safety and environment of the practice. These were all kept up to date to help ensure patients and staff remained safe.

Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. The practice had systems in place to monitor patients within the population groups. For example, the practice monitored patients who had a long term condition and offered recalls were required. Those patients with long term conditions were also reviewed with district nursing staff and hospital contacts. If required, palliative care representatives were engaged in detailed discussions regarding on-going care assessments.

The practice monitored patients health who were over the age of 75 and all patients had a named GP. All enquiries from this patient group where directed to their named GP to ensure continuity of care and support.

Patients with long term conditions who had changes identified in their condition or new diagnoses were discussed at practice monthly clinical meetings. That allowed clinicians to monitor treatment and adjust according to risk. Therefore the practice was positively managing risk for patients. For example patients who required palliative care were discussed in multi-disciplinary team meetings and the practice was following the 'gold standards' framework for palliative care.

There were emergency processes in place for identifying acutely ill children and young people, and examples were given to us of referrals they made. The practice had appropriate equipment in place to deal with medical emergencies for all patient groups.

The staff gave examples of how they utilised clinical templates on the patient administration system. For example, patients experiencing mental health conditions and the efficient use of their recall system.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. All of the staff we spoke with knew how to react in urgent or emergency situations.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, fire emergency, heating provider and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. Staff we spoke with were aware of the practice business continuity arrangements and how to access the information they needed in the event of emergency situations.

Good

Are services safe?

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GP and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed and updated when appropriate.

Staff told us they received guidance issued by NICE electronically and that the practice manager was responsible for circulating them to clinical staff. We saw examples where treatment guidance had been circulated to staff and acted on. The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards for the referral of patients to secondary care and patients with suspected cancers who needed to be referred and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last two years. The audits were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The two audits we looked at were calcium and vitamin D therapy and cancer history monitoring. The practice used these audits to demonstrate the changes implemented to patients health care provision since initial diagnosis.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients who were current smokers whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months was 100%. The practice met all the minimum standards for QOF in diabetes/depression/chronic obstructive pulmonary disease COPD (lung disease) and dementia, and was overall above performance in the CCG and England averages. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake or be involved in the audit process.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw that palliative care patients were also discussed daily when there were changes to their condition.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire and basic life support. The GP was up

Good

Are services effective?

(for example, treatment is effective)

to date with their yearly continuing professional development requirements and had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which goals and objectives were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example basic life support and COPD management. We received positive feedback from all staff we interviewed.

The Practice nurse was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and review of patients with long term conditions. The nurse had extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and was also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by social workers, palliative care nurses and decisions about care planning was documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments). Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the clinical and the patients care teams instant access to medical records at all of their surgeries. This enabled staff in the practice to see and treat patients from other practices registered within the group. These records provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems in place to provide staff with the patient information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a processes in place to help

Good

Are services effective?

(for example, treatment is effective)

staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Staff were able to identify patients who may need to be supported to make decisions and identify where a decision may need to be made in a person's 'best interest'. The practice offered an advocacy service where patients were identified as needing support during their care decisions. Information was available to all patients about this.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests was taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice asked new patients to complete a new patient registration form. However, the form had been copied multiple times and some of the information on the form was not legible. We spoke to the practice manager about this and they assured us they would have some new forms re-printed for patients. The practice may then invite patients in for an assessment with one of the clinical staff. This provided the practice an opportunity to promote different methods of communication such as electronic communication. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical screening uptake was 100%, which was above the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. Performance for national COPD, cancer screening and heart failure in the area was all above average for the CCG and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was slightly below average for the CCG, and again there was a clear policy for following up non-attenders in the practice, these were also discussed with the Health Visitors.

The practice kept a register of patients who are identified as being at high risk of admission, or at End of Life and have up to date care plans in plans in place for sharing with other providers. We saw that patients in this group were followed after admissions and the practice used resources available to prevent readmission. Examples of these were the development of care plans and working with the community multi-disciplinary team. We saw that people received regular structured annual medication reviews for polypharmacy.

There were comprehensive screening and vaccination programmes which were managed effectively to support

Good

Are services effective?

(for example, treatment is effective)

children and young people. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

People experiencing poor mental health in the practice had access to services. We saw that people with severe mental health problems received an annual physical health check. We saw staff had undertaken additional training in mental health. There was a good understanding and evidence of signposting patients to relevant support groups and third sector organisations operating in the local area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey completed by patients. The evidence from this source showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was 94%.

Patients completed CQC comment cards to tell us what they thought about the practice. We also spoke with five patients on the day of our inspection The majority of comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected and staff were compassionate to their needs.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Appropriate curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm and professional manner. Staff we spoke with were aware of the importance of providing patients with privacy. They told us they could access a separate treatment room off the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 75% said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were in line with national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Staff were able to describe how they would offer this service directly to known patients that did not have an interpreter attending an appointment with them.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 98% of practice respondents said the last appointment they got was convenient and 86% felt the GP was good at listening to them. Both these results were above average compared to the CCG area.

Notices in the patient waiting room, on the TV screen and patient 'ipad kiosk' also told patients how to access a number of support groups and organisations. The

Good

Are services caring?

practice's computer system alerted the GP 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.

GP's referred people to counselling services where necessary, and the practice 'ipad kiosk' and handbook contained links to support organisation and other healthcare services. Patients could also search under their local area for further advice and support.

The practice provided information and support to patients who were bereaved and for carers. The practice sign posted patients to health and social care workers and referrals were made on behalf of patient's relatives and carers as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Examples of these were the introduction of a second partner as part of the practice succession planning and continuing dementia care.

The practice was currently re-implementing its patient participation group (PPG). We spoke with the originator of the group and they were in the process of selecting new members of the group to regroup its activities over the coming months. Therefore this practice did not currently have an active PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

For example, they recognised those with a learning disability, mental health, veterans outreach service and the older population.

Staff were knowledgeable about how to book interpreter services for patients where English was their second language. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The practice had recognised the needs of different groups in the planning of its services. Staff could access other support services, for example Age UK or the Alzheimer's Society for up to date information in order to support patients as needed. The GP told us that the surgery provided counselling services to veterans and ex-military families in the local area.

Patients with disabilities and patients with pushchairs were able to access all areas of the building. The practice also had accessible toilet facilities that were available for all patients attending the practice including baby changing facilities. An audio loop was available for patients who were hard of hearing.

Access to the service

Appointments were available from 09.30am to 17.00pm Monday to Friday and an extended appointment until 18.30pm on a Wednesday. Saturday appointments were not currently available. The practice also offered express clinics for example; Family planning, Chlamydia screening and Minor surgery.

Comprehensive information was available to patients about appointments in the practice handbook. This included how to arrange urgent appointments, home visits and how to contact out of hours services. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. The practice did not have a website.

We found that the practice was accessible to patients with limited mobility. Ramp access was provided for entry into the building. Facilities for patients with limited mobility had hand and support rails fitted to assist them where required. The consulting rooms were accessible for patients with limited mobility and there was also a toilet for disabled patients. Other facilities were available for mothers and babies; for example a treatment room was utilised for baby changing facilities.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care homes by request.

The majority of patients were generally satisfied with the appointments system. They confirmed that they could see the GP on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us they the waiting times are excellent and has never needed to wait more than 10 minutes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available outside of school hours for children and young people. They were also able to access clinics dedicated to young people at the New Waltham surgery should an earlier appointment be needed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints which was the practice manager. There was also an email address and postal address provided for the complaints liaison service.

We saw that information was available to help patients understand the complaints system in the waiting area and in the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at one complaint received in the last 12 months and found this had been satisfactorily handled and dealt with in a timely way. We saw that the practice had an openness and transparency when dealing with the complaints.

We spoke with the originating member of the PPG and they felt that the practice always took complaints seriously, handled them in a timely manner and resolved them fully. They also felt previously that the practice took suggestions from the PPG seriously and acted on them with patient satisfaction in mind.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and mission statement to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's future plans.

Staff told us that they had weekly meetings with their manager were their role in meeting these goals was discussed. Examples of the practice mission statement included treating everyone as individuals and putting patients at the heart of all practice developments and services.

The practice values, vision and goals were discussed with staff at their induction . We spoke with three members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw evidence of good communication with staff. The practice also had an extensive staff consultation process in place to ensure staff were consulted and their opinion valued.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and saw that processes were in place to ensure staff had read the policy and when. All of the policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had robust arrangements for identifying, recording and managing risks. We saw that risks identified were discussed at team meetings and updated in a timely way.

The practice held regular practice meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes of staff meetings that they were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and with their line manager. We also noted that there was regular staff consultation.

The practice manager had responsibility for HR management across the practice. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We saw that these were easy to understand. We were shown the electronic staff handbook that was available to all staff, which included sections on areas such as equality and harassment and bullying at work. The handbooks were also tailored to the different staff roles such as GPs and administration staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. The practice manager told us that the PPG was currently inactive and the practice had recently held discussions with a patient that was willing to engage with the practice and re-introduce a PPG membership. We spoke with the PPG member and they told us they were currently contacting a number of members of the patient list to start meeting in the practice in the coming months.

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice learned from and improved outcomes for patients. For example the procedures to follow when a needle stick injury occurs and the revalidation of prescription scripts for patients with known allergies.