# Watercress Medical, Mansfield Park Surgery

## Quality Report

Mansfield Park Surgery
Lymington Bottom Road
Medstead
Alton
Hampshire
GU34 5EW
Tel: 01420 562922
Website: http://www.easygp.net/site9458/index.html

Date of inspection visit: 1st October 2014
Date of publication: 22/01/2015

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

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive inspection of this service on 1 October 2014.

We have rated the practice as good overall.

The practice was centred on good patient care. Patients told us they could get an appointment when needed and had sufficient time to discuss their health concerns with the GP.

Our key findings were as follows:

- The practice involved community services so patients could see the right person for their medical condition.
- Patients rated the practice above the regional average for ability to get an appointment to see or speak to someone, their confidence with nursing staff and being given enough time for their nurse appointments.
- GPs and nurses received appropriate training and professional development supervision and training.
- The practice regularly assessed and monitored the quality of its services and actions were taken to improve them when necessary.
- Patients were treated with respect, kindness and dignity and the practice was able to respond to any patient emergencies.

However, there was also an area of practice where the provider needs to make improvements.

Importantly, the provider should:

- Ensure medical emergency medicines are available and fit for purpose (within use by date).

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 was rated as good for safe.

Staff understood and fulfilled their responsibilities to raise concerns, and 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 was rated as good for effective.

Data showed patient outcomes were at or above average for the locality.National Institute for Health and care Excellence (NICE) guidance was referenced and used routinely.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

Staff had received training appropriate to their roles and further training needs had been identified and planned.

The practice had completed appraisals and personal development plans for all staff. Multidisciplinary working was evidenced.

**Are services caring?**

Good

The practice was rated as good for caring.

Data showed patients rated the practice higher than others for almost all aspects of care.

Feedback from patients about their care and treatment was consistently and strongly positive.

We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

# Summary of findings

**Are services responsive to people's needs?**

Good

The practice was rated as good for responsive.

The practice reviewed the needs of their local population and engaged with the NHS Local Area Team and clinical commissioning group to secure service improvements where these were identified.

Patients reported good access to the practice and had a named GP and continuity of care, with urgent appointments available the same day.

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

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

There was evidence of shared learning from complaints with staff and other stakeholders.

**Are services well-led?**

Good

The practice was rated as good for well-led.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place.

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

The practice proactively sought feedback from patients and this had been acted upon. The practice had an active patient participation group.

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

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

The practice was rated as good for the care of older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice offered home visits and rapid access appointments for patients who had complex health care needs.

Annual flu vaccinations were provided at the practice and in patient's homes if they were unable to attend the practice.

Patients had a named GP and an annual health check and were offered double appointments in order to give them the time to discuss their health needs.

The practice held regular multidisciplinary meetings with community nurses and social workers to discuss patients care and end of life care.

The practice worked with a mental health worker specifically trained in helping older people.

Care plans were in place for the most vulnerable older people at the practice. This included 20 minute appointments or home visits usually with a carer or family member accompanying the patient to discuss, formulate and agree their care plan.

### People with long term conditions

Good

The practice was rated as good for the care of people with long term conditions.

Phone appointments were arranged to monitor patients. For example, adjusting medicine dosages, when instruction were received from another care provider such as a hospital.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health.

When needed, longer appointments and home visits were available.

Patients had a named GP and structured annual reviews to check their health and medication needs were being met.

The practice identified patients with multiple conditions and combined appointments for reviews, so only one visit to the practice was required.

# Summary of findings

Patients could have their blood tests carried out at the practice and could book appointments in advance such as for monthly monitoring.

Practice nurses and GPs held specialist portfolios which included heart conditions, diabetes, respiratory conditions and dementia.

GPs issued fitness prescriptions for patients to attend local leisure centres and exercise.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people.

Systems were in place for identifying and following-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 relatively high for all standard childhood immunisations.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

Appointments were available outside of school hours and the premises were suitable for children and babies.

We were provided with good examples of joint working with midwives, health visitors and school nurses.

Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

There were two designated midwives who had regular clinics in the practice and ran a shared care system.

The practice had an in house blood monitoring service and there were antenatal care plans so GPs stayed in contact with their patients.

Post natal checks were carried out by the patient's usual GP if possible.

The practice had a designated health visitor with regular clinics, open access and phone contact.

A full range of contraceptive services. Chlamydia testing, plus advice regarding sexual health was offered.

# Summary of findings

There was a visiting young persons' mental health worker. The practice was responsive to the urgent needs of children and recognised that a small child or baby's condition could change rapidly. Children were seen as promptly as possible with same day access to appointments..

Staff were trained to consult the duty doctor promptly if concerned.

**Working age people (including those recently retired and students)**

Good

The practice was rated as good for the care of working-age people (including those recently retired and students).

The practice adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

This included extended hours opening in the morning to cater for those who worked.

Patients had a named GP and annual health checks were offered to patients over 40 years old.

There were procedures in place for temporarily registering students who had returned to the area during breaks from university.

There was a daily 'duty doctor' system with triage. Patients phoning in for appointments or needing on the day help were added to a duty doctor list for phone call or triage.

This can be given as a time slot, e.g. between 12pm and 2pm, and this helped people who worked plan their days.

Telephone appointments were also available for people who were working and could not attend the practice in person.

**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 accessed translation services for patients who did not have English as their first language.

The practice had a learning disabilities register with trained practice leads.

There were three learning disability residential homes the catchment area. Annual checks and reviews were provided by the practice staff.

# Summary of findings

**People experiencing poor mental health (including people with dementia)**

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice offered all patients on the mental health register annual health checks. Double appointments were available for patients in this group and systems were in place for monitoring medication levels and repeat prescriptions.

The practice had in place advance care planning for some patients who had dementia.

The practice informed patients about various support groups and voluntary organisations and local counsellors.

# Summary of findings

## What people who use the service say

We spoke with five patients and collected 19 comment cards during our inspection. We also reviewed the last two patient surveys.

One of these surveys was the national GP survey that was carried out in 2014. The practice scored higher than the national average in areas of being treated with care and feeling listened to.

We were told that patients were given enough time during appointments to discuss their needs and we confirmed this by speaking with patients and looking at the patient surveys.

Patients told us they could get an appointment with a GP at a time that suited them and if it was urgent they could be seen on the same day. Patients told us the practice was clean and they felt safe. They all told us the staff were responsive to their individual needs.

# Watercress Medical, Mansfield Park Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist adviser.

## Background to Watercress Medical, Mansfield Park Surgery

Watercress Medical operates from a purpose built surgery in a semi-rural location covering approximately 200 square miles.

There are approximately 7200 patients currently registered with the practice and there is above average elderly population covering a wide social and economic range.

The practice has six GP partners (WTE 3.6) of which three are male and three are female. GPs are supported by three practice nurses and two health care assistants. Other staff included reception and administration teams and a practice manager.

The practice has a dispensary catering for patients who live further than one mile from a pharmacy.

There a variety of other health staff that the practice has support from including a midwife, social worker, primary and older person mental health workers and community nurses.

The practice is open from 8am to 6:30pm Monday to Friday and has extended hours opening from 7am on Tuesdays to Fridays.

The practice has higher patient satisfaction when compared with other practices in the clinical commissioning group area.

The practice has opted out of providing Out-of-Hours services to their own patients and refers them to another provider.

We carried out our inspection at the practice's only location which is situated at;

Watercress Medical, Mansfield Park Surgery,

Lymington Bottom Road

Medstead

Alton

Hampshire

GU34 5EW

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection was carried out on 1st October 2014 to check whether the provider was meeting

# Detailed findings

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.

This provider had not been inspected before and that was why we included them

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These included local Healthwatch, the clinical commissioning group and NHS England local area team.

We carried out an announced visit on 1st October 2014. During our visit we spoke with a range of staff including GPs, Nurses and reception staff and spoke with patients who used the service.

We observed how people were being cared for and talked with family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Mansfield Park Surgery has a high proportion of 'rural poor' (e.g. retired farm workers). This group tends to be a self-reliant, but often extremely poor.

Good

# Are services safe?

## Our findings

### Safe Track Record

The practice used systems to report and record safety incidents, near misses and national patient safety alerts. The practice had a significant event policy and staff knew how to notify the GPs of incidents. We saw the policy and found it to be clear and easy to follow.

Significant events were recorded on a practice specific template. These were discussed and peer reviewed and an action plan was completed to deal appropriately with the event.

The practice had received only seven complaints in the previous 12 months. This was low when compared with other practices of similar sizes. We reviewed all of the complaints and found they were accurately recorded and had been investigated in a timely manner. For example we saw records of dates and times complaints were received and responded to.

The practice had systems and processes in place to carry out cycles of clinical audit. We reviewed several audits, including contraception, and found the processes were appropriate. For example the practice used the Hampshire Local Medical Committee (LMC) template which captured key information and actions plans which made it easier to communicate plans to patients, out of hours and ambulance services if needed.

### Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. The practice had a suitable policy and procedure that all the staff we spoke with were aware of. We looked at several significant event audits and found them to be appropriately recorded and investigated.

The practice was open when investigating internal and external incidents. For example, a patient smear test had been recorded in the wrong patient's notes. We saw the practice had now added dates of birth and addresses to checklists to prevent a similar incident from happening again.

Significant event audits were carried out following any patient safety incidents. We saw an example where the dispensary had alerted the GP to an inadequate dose of pain relief on a prescription prior to this being administered to the patient. This incident was recorded and dealt with appropriately and the correct dose was given to the patient.

### Reliable safety systems and processes including safeguarding

The practice had systems and processes to help staff identify and respond appropriately to any safeguarding concerns.

There was a named safeguarding lead who had completed level three safeguarding training for vulnerable adults and children. Staff knew who the safeguarding lead was. They were also aware of how to report any safeguarding concerns.

We saw evidence that all of the staff who worked at the practice had also received training in safeguarding. Training records confirmed that all clinical staff, including GPs and practice nurses, had completed level three safeguarding training and administration staff had completed level two training.

There were systems in place to identify vulnerable adults and children. For example, any reports or letters relating to children failing to attend hospital appointments were passed to the lead GP. These were then discussed with health visitors and/or at child protection meetings.

Systems were also in place for identifying and following-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. This included highlighting patient records and reviewing their circumstances on their next appointment

There was a working relationship with a community matron and a community psychiatric nurse and social worker regularly visited the practice. This was set up to help vulnerable adults and older people. We saw evidence that discussions took place with social services when needed.

The practice had a chaperone policy that had been updated and reviewed in April 2014. A chaperone is a person who accompanies another person to protect them from inappropriate interactions. Information about how to request a chaperone was made available to patients through the patient information leaflet and was also displayed in reception and in each consultation room.

Good

# Are services safe?

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

**Medicines Management**

The practice had a dispensary. This was for patients, who lived further than one mile away from a pharmacy, to collect prescriptions at the practice. We spoke with the dispensary manager and three other members of the dispensary team. All of the team had received approved training and their qualifications and certificates were displayed for all patients to see. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. For example all medicines were double checked with another member of the prescribing team before being issued. We observed this process was working in practice.

We observed how the staff handled and administered medicines to patients. We also looked at how medicines were stored. All medicines were checked by two members of the dispensary team before being handed over to patients after identification checks were made.

We were shown how the dispensary system worked and how any safety concerns were addressed. The practice had a system for reporting 'near misses'. A near miss is when a mistake, however minor, is recorded and investigated. This was used as a means of learning and refining their systems to prevent recurrence. We examined the details of an incident where a mistake had been made. We saw a full audit trail had been recorded, what the potential harm was, why it happened and how it was to be prevented from happening again.

We saw that any incidents were discussed at dispensary team meetings in order to share learning outcomes.

The practice had systems to deal appropriately with controlled drugs. The GPs did not carry controlled drugs with them when on home visits and access to the controlled drugs cabinet was restricted. We saw the issuing and destruction of any controlled drugs was appropriately recorded.

The practice used up to date policies and procedures for prescribing and administering medicines. All of the staff were aware of the contents of the policy.

The practice used a computer system which had systems to warn GPs of potential problems with prescribed medicines, clashes between different medicines, allergies and whether a medicine was classified as a controlled drug. This helped with appropriate, effective and safe prescribing of medicines.

We checked medicines and vaccinations that were stored in the treatment rooms and medicine fridges and found they were all stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff who demonstrated the system they would follow in the event of a potential fridge failure.

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.

**Cleanliness & Infection Control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

Patients told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had daily and weekly checklists for cleaning procedures and records showed the toilets were checked twice a day.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice about the practice infection control policy and carry out staff training.

Staff received training about infection prevention and control specific to their roles.

Good

# Are services safe?

The infection control lead carried out annual audits and improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were also discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. One example we were given was the 'use of gloves when examining patients policy'. There was also a policy for dealing with needle stick injuries.

Hand hygiene information and techniques was displayed around the practice and in staff and patient toilets. Hand washing sinks with liquid hand 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 germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Clinical waste was stored and disposed in line with current waste regulations. We saw that waste consignment notes were also kept in accordance with the regulations.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatment.

Records confirmed that all equipment, including blood pressure monitors, defibrillator and baby scales was tested and maintained regularly and maintenance logs and other records were kept.

All portable electrical equipment was routinely tested and displayed stickers indicating the last test was carried out in November 2013.

### Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Appropriate recruitment checks for new staff were carried out before they started to work at the practice. Checks included proof of the applicant's identification, qualifications, registration with appropriate professional bodies and criminal records checks via the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice has a system of employing locum GPs. A locum GP is a GP who temporarily fulfils the duties of another GP when needed. We saw evidence that showed locums had up to date qualifications and revalidation and were familiar with the specific workings of the practice. This is because the practice tried to use the same locums wherever possible.

### 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.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was a lead health and safety representative.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

All staff had received training in basic life support within the last 12 months. Emergency equipment was available which included access to oxygen and an automated external

Good

# Are services safe?

defibrillator (this is a piece of equipment used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment. Records we saw confirmed this equipment was checked monthly.

We found the practice had three types of methods for dealing with anaphylaxis (severe allergic reaction). These included adrenaline phials, and an epipen for adults and for children.

Emergency medicines were available and stored in a secure but accessible area of the practice and all staff knew their location.

A process was set up to check that emergency medicines were kept within their expiry date and suitable for use. However, one type of medicine used to treat a child experiencing an allergic reaction had passed its expiry date of January 2014.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Emergencies identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. Records confirmed that staff were up to date with fire safety training and that regular fire drills had been carried out.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

GPs and nursing staff could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. An example of this was the annual peer review audit for diabetes. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best outcomes for patients. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

An example of this was the admission of a patient with heart failure to a local hospital to help manage their breathing difficulties. They were also prescribed a course of antibiotics that could be initiated if the patient displayed symptoms of chest infection. Evidence showed this had been agreed between the patient, their carer and the GP.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

### Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included long acting reversible contraception, dispensing audits and discharge summary audits. Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used.

The practice computer system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the local clinical commissioning group. 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 comparable to other services in the area. For example patient satisfaction.

### Effective staffing

Practice staff included GPs, nursing, managerial and administrative staff. We reviewed five staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training.

Staff we spoke with confirmed they were able to obtain further professional development. For example, one member of staff had become a diabetes specialist whilst another was undertaking training in spirometry. Spirometry is a simple breathing test that measures the amount of air a person can blow out of the lungs.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date arranged for revalidation. Every GP is appraised annually and every five years undertakes a full assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

Good

# Are services effective?

(for example, treatment is effective)

### Working with colleagues and other services

The practice worked with other care providers to meet patients' needs and manage their complex conditions.

Blood results, x/ray results, letters from the local hospital including discharge summaries, Out of Hours providers were either received electronically or by post. The practice had procedures outlining the responsibilities of all relevant staff in dealing with any issues arising from communications with other care providers. Staff understood their roles and felt the system in place worked well.

GPs who had patients with complex needs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice also liaised with visiting specialist nurses for some patients with long term conditions and referred patients as appropriate. For example MS nurse, Parkinson's Nurse, heart failure nurse.

The practice held multidisciplinary team meetings on a weekly basis, and as and when needed, to discuss patients with complex care needs , those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were 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 had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system that had recently been implemented, and commented positively about the system's potential. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had a system for sharing information and data with the local clinical commissioning group (CCG) and the locality group which was made up of three GP practices. Information about referrals, emergency attendances, elective and non-elective admissions was shared and discussed. This enabled the practice to compare its data with other practices and identified trends in the local area.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 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 example, ensuring that children over the age of 16 understood the choices of care and treatment available to them.

### Health Promotion & Prevention

The practice 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 patient 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.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and it was practice policy to offer all of them an annual physical health check. Staff told us the health check also included their patients' emotional and mental health needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The annual flu campaign was advertised on the practice website and in and around the practice through posters and leaflets.

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey carried out in 2014 and a survey of 75 patients carried out by the practice's patient participation group and patient satisfaction questionnaires undertaken by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

When compared with other practices in the CCG, Watercress Medical was a lot higher than the average score in the GP patient survey. For example 89% of respondents said the nurse or GP was good at explaining treatments and test results compare with an average of 76%.

Patients completed Care Quality Commission comment cards to provide us with feedback on the practice. We received 19 completed cards and all of them were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful, friendly and caring. They said staff treated them with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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.

### 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 89% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

Patients we spoke with 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.

### Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Bereavement support is provided by the GPs as and when needed. Family members were signposted to relevant resources such as bereavement counselling. The practice also holds regular end of life care meetings. These meetings include the GPs, community nurses and the community matron. We saw minutes of these meetings that showed patient and family needs were met on an individual basis.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. 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 several local care homes on a specific day each week, by a named GP and also to those patients who needed one.

We saw evidence of the practice working with the community matron and community team, as well as a local geriatrician. This helped in looking after the population and ensuring good information exchange when care is transferred from the practice to other services and back. One example we saw was a patient referral to a hospital for admission. This was followed by a discharge letter and the GP contacting the patient after being discharged. Part of the contact involved talking about medication requirements and care needs. Arrangements with community nursing team were made to ensure the patients care needs were met.

The practice had an active patient representative group. We spoke with the chairperson of the group who told us the GPs were active in addressing any issues that were raised. One of the issues that had been discussed was with problems some patients had in opening medicines and these were able to be provided in different packaging.

### Tackling inequity and promoting equality

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events. Training records we saw confirmed this. All of the staff we spoke with were aware of the equality and diversity policy that had been reviewed in 2013.

The premises and services had been adapted to meet the needs of people with disabilities. For example, there was step free access to the practice, corridors and doors were wide enough to facilitate use of mobility scooters and wheelchairs.

The practice had a population of 96% English speaking patients though it could cater for other different languages through translation services.

### Access to the service

Appointments were available from Monday to Friday 8am to 6:30pm. Early morning appointments (Extended Hours Service) were available for appointments between 7am and 8am Tuesday to Friday. These appointments were primarily for people who genuinely find the usual surgery times difficult (such as commuters).

There was a daily 'duty doctor' system with triage. Patients phoning in for appointments or needing 'on the day' help were added to a duty doctor list for phone call or triage. This was given as a time slot, e.g. between 12pm and 2pm, and this helped people who were working or busy. The duty doctor could open appointments at convenient times, for that patient, or they could see them on the day as an urgent appointment.

The practice also offered telephone appointments. These could be added in advance to the patient's usual doctor list, meaning that appointments could coincide with their days off or for convenience.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. The practice had plans to introduce an online appointment booking service following the introduction of a new computer system.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on their circumstances. Information on the Out-of-Hours service was also provided to patients through leaflets around the practice, outside the surgery and through the practice website.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. All of the comments received on the comment cards told us that patients did not feel rushed during appointments and had all the time they needed to discuss their needs.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Comments received from patients showed that patients, in urgent need of treatment, had been able to make appointments on the same day of contacting the practice. One patient we spoke with confirmed they had needed an appointment and was seen on the same day.

We saw that the waiting area was large enough to accommodate patients who were wheelchair users and prams and the treatment and consultation rooms were accessible to both. Wheelchair accessible toilet facilities were available which included baby changing facilities.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice. Information about making complaints was available on the practice website and on leaflets displayed in the waiting area. Staff we spoke with were aware of how to report, record and escalate complaints

We looked at all seven complaints received in the last twelve months and found these were all satisfactorily handled and dealt with in a timely way.

Evidence of learning was seen. One example we saw was how the practice took action in terms of recording telephone discussions with patients. The practice now has a telephone message book with which to do so. This change was prompted by a patient complaint that staff had misunderstood what had been asked of them. Since the introduction of this book there have been no similar complaints.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

# Are services well-led?

Good

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

## Our findings

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at ten of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All ten policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review which showed that the practice had the opportunity to measure their service against others and identify areas for improvement.

The practice had completed a number of clinical audits, for example diabetes, contraception and prescribing.

### Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead for infection control and another lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. All of the staff we spoke with told us they had been trained to be able to provide cover in other staff's roles

Team meetings were held at least every month. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings.

### Practice seeks and acts on feedback from users, public and staff

The practice gathered feedback from patients through patient surveys, comment cards and the patient participation group (PPG). The practice had an active PPG. One example we saw was the plan to improve access for all by removing the kerb stones around the path leading to the practice.

The practice manager showed us the analysis of the last patient survey which was carried out in conjunction with the PPG in 2014. The results and actions agreed from these surveys were posted on the practice website.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients and said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management

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 & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that annual appraisals took place.