St Mary Street Surgery

Quality Report

St. Mary Street Surgery
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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.

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Summary of findings

Overall summary

St. Mary Street Surgery is a semi-rural practice which provides primary care services to patients living in Thornbury, South Gloucestershire, Monday to Friday during working hours. In addition, there are a range of clinics for all age groups, specialist nursing treatment and support.

As part of our inspection we spoke with other organisations, such as: the South Gloucestershire Clinical Commissioning group; the local Healthwatch; and other healthcare providers, to share what they knew. We also talked with patients and staff. We looked at the practice facilities which with the exception of the treatment room had not had the decoration updated.

The practice used a range of information to identify risks and improve quality regarding patient safety. They had a system for reporting, recording and monitoring significant events. The practice had systems which recognised and supported patients who were at risk of abuse. The practice had written guidance to support staff with the recruitment and selection process of new staff. Patients were treated by sufficient, suitably qualified staff. Patients were cared for in a safe environment. The practice had the equipment, medicines and procedures to manage foreseeable patient emergencies. Patients were protected from the risks of unsafe medicine management procedures. Patients were cared for in an environment which was clean and reflected good infection control practices.

Patients' care and treatment was delivered in line with recognised best practice standards and guidelines. The practice met nationally recognised quality standards (the Quality and Outcomes Framework - QOF) for improving patient care and maintaining quality. For example, the management of patients with long term conditions and compared favourably with other practices in the area. Patient care was improved by the effective monitoring of treatment. Patients' rights were protected with regards to the consent process. Patients' care was co-ordinated and managed by the practice to enable appropriate referrals to other healthcare providers. Patients had access to a range of health promotion information.

Patients were generally positive about their care and treatment. This was supported by results from the 2014 GP National Patient Survey, which demonstrated 95% of respondents from the practice had confidence and trust in their GP. Patient privacy and confidentiality was not easily maintained in the practice waiting area. The practice was aware of the situation and had started to address the issue, for example: relocating a telephone and work station to a room away from patient areas. Patients were involved in treatment choices.

Patients were generally able to get an appointment when they needed it. Of the respondents who completed the 2014 GP National Patient Survey 98% said their last appointment was convenient for them. However, there were areas requiring change, for example: contacting the practice by telephone during peak periods involved long waiting times. Patients with mobility needs could not gain access to the practice without assistance. The main door was not automated and there was no doorbell to summon assistance. Patients with communication difficulties had access to help. Patients had access to the practice complaints procedure via the practice leaflet and in the practice waiting area.

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. Patients' views on the service were listened to. The practice demonstrated a focus on learning. GPs and nurses were encouraged to update and develop their clinical knowledge and skills. The practice monitored significant events and used the learning to improve practice.

The practice supported older patients and patients with long term conditions by offering advice and support through specialist clinics, screening and evidence based information. The practice supported mothers, children and young people by working with other healthcare providers. The practice supported the working age population and those recently retired by offering a flexible appointment system. The practice supported patients in vulnerable circumstances by the early identification and protection of patients at risk. The practice supported patients experiencing poor mental health by regular monitoring of their treatment and support needs.

Summary of findings

Please note that when referring to information throughout this report, this relates to the most recent information available to the Care quality Commission (CQC) at that time

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice used a range of information to identify risks and improve quality regarding patient safety. There were systems for reporting, recording and monitoring significant events.

There were processes which recognised and supported patients who were at risk of abuse. Staff we spoke with were aware of their roles and responsibilities with regards to protecting patients from abuse or the risk of abuse. However, the lead GP did not have level three safeguarding children training in line with national guidance.

The practice had written guidance to support staff with the recruitment and selection process of new staff. The practice had a system to enable sufficient staff numbers to meet service requirements.

Patients were cared for in a safe environment. The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies. Practice records demonstrated equipment was regularly serviced and maintained.

Patients were protected from the risks of unsafe medicine management procedures. Medicines were stored, checked and records accurately maintained in line with legal and safety requirements.

Patients were cared for in an environment which was clean and reflected good infection control practices. Staff had access to appropriate information about their role and responsibilities in protecting patients from the risk of infection.

Are services effective?

Patients' care and treatment was delivered in line with recognised best practice standards and guidelines. The practice met nationally recognised quality standards for improving patient care and maintaining quality and compared favourably with other practices in the area.

Patient care was improved by the monitoring of treatment. The practice had a system in place for completing clinical audit cycles to evidence treatment was in line with recognised standards.

Patients' rights were protected with regards to the consent process. Staff were confident in their understanding of their legal and ethical responsibilities for gaining informed consent prior to treatment.

Summary of findings

Patients' care was managed by the appropriate healthcare professionals. The practice worked with other primary care providers such as community nurses to co-ordinate care. Patients had timely referrals to secondary care services. Communication between the practice and Out of Hours service was generally effective.

Patients had access to a range of health promotion information. The practice offered specialist clinics for patients such as smoking cessation where health promotion discussions were part of their treatment plan.

Staff received the training and support to undertake their role. However, staff did not have a documented appraisal in line with the practice HR policy. Staff told us and we saw from records they had access to training and opportunities to develop. The practice had an action plan to implement a written appraisal and clinical supervision programme by December 2014.

Are services caring?

Are services caring?

Patients were generally positive about their care and treatment. Patients we spoke with were pleased with the care and concern demonstrated by staff. This was supported by results from the 2014 GP National Patient Survey, which demonstrated 95% of respondents from the practice had confidence and trust in their GP. We observed staff were supportive in their interactions with their patients and generally had the skills to support patients appropriately.

Patient privacy and confidentiality was not easily maintained in the practice waiting area. We observed the design of the reception and waiting area meant conversations between the receptionist and patient could easily be overheard. The practice was aware of the importance of maintaining confidentiality and privacy and, had an action plan to address the issues.

Patients were involved in treatment choices. Patients told us doctors and nurses explained their care and they were involved in care decisions. 83% of the respondents who participated in the GP National Patient Survey 2014 said GPs involved them in care decisions, 90% felt the GP was good at explaining treatment and results.

Are services responsive to people's needs?

The practice had made some adjustments to the building for patients with mobility needs such as a ramp to the door and a

Summary of findings

lowered reception desk for wheelchair users. However, the main door was not automated and there was no doorbell to summon help. We observed staff offered help when they were aware a patient needed to enter the building.

Patients were generally able to get an appointment when they needed it. The practice had extended the surgery opening times and patients could wait to see a GP if their appointment was urgent. The annual GP National Patient Survey 2014 indicated 98% of respondents last appointment was convenient for them. However, patients told us contacting the practice by telephone during peak periods involved long waiting times. This had been addressed by the practice by introducing electronic booking of appointments and email contact.

Patients had access to the practice complaints procedure. There was information available in the practice leaflet and in the surgery.

Are services well-led?

Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. Staff told us they worked well as a team. We observed staff upheld the values of the practice: personal, friendly and patient centred.

Patients' views on the service were listened to and were used to improve services. The practice used a range of approaches to collect patient feedback. They had recently set up a virtual patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. There was a satisfactory system to review complaints.

The practice valued learning. GPs and nurses were encouraged to update and develop their clinical knowledge and skills. The practice provided training for doctors specialising in general practice

Patients were protected from risk. The practice measured, collected and monitored data to meet nationally recognised standards for improving patient care and maintaining quality. The practice's internal quality systems were regularly monitored and recorded which assisted in the early identification of risks to patients.

Staff did not have a documented performance appraisal. The practice had begun to address the issue.

Summary of findings

The six population groups and what we found

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

Older people
The practice supported older patients by enabling access to services without patients having to attend the surgery. The practice provided screening and specialist clinics to promote wellbeing, the early detection of symptoms and, the protection of patients at risk of complications of disease.

People with long-term conditions
The practice supported patients with long term conditions by offering advice and support through specialist clinics, screening and evidence based information. Staff worked with other health care providers to reduce hospital admissions and enable patients to be treated at home.

Mothers, babies, children and young people
The practice supported mothers, children and young people by working with other healthcare providers and offered advice and support through specialist clinics, screening and information.

The working-age population and those recently retired
The practice supported the working age population and those recently retired by providing screening for common medical conditions. They offered a flexible appointment system and access to information and services via the practice website.

People in vulnerable circumstances who may have poor access to primary care
The practice supported patients in vulnerable circumstances by the early identification and protection of patients at risk. Patients had fair and equal access to treatment and support.

People experiencing poor mental health
The practice supported patients experiencing poor mental health by regular monitoring of their treatment and support needs.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with 14 patients attending the practice and looked at 19 patient comment cards. In addition we looked at feedback from the NHS choices website and the GP National Patient Survey 2014.

Most patients we spoke with told us they were satisfied with the treatment and support they received. They appreciated the friendly and person centred approach of staff. A number of patients had been registered with the practice for many years and said they would not consider changing doctors. However, some patients said they had difficulty getting through to the practice by telephone. Three patients commented the decorative appearance of the practice required updating. Two patients with mobility difficulties told us they required assistance to access the building as the main door was not automated.

Patient feedback told us they did not experience difficulties getting a suitable appointment although it was not always with the doctor of their choice. The patients said this was generally when they required an emergency appointment. This was confirmed by the practice.

Patients said although they were not familiar with the procedure for making a complaint they were confident their GP or practice manager would manage their concerns appropriately.

Areas for improvement

Action the service SHOULD take to improve

- The practice should improve access to the building and décor for the overall patient experience.
- The practice should provide alternative forms of information for patients such as easy read formats, pictures and models.
- The practice should implement a formal appraisal for staff.
- The plans to protect patient privacy and confidentiality in the reception area should be implemented in line with the practice action plan
- The practice should consult with the appropriate agencies to ensure the appropriate arrangements are implemented with regards to fire safety.
- Staff should be up to date with safeguarding training. Training should be at the appropriate level for the individual's roles and responsibilities.

St Mary Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor and an expert by experience (a person with experience of using health care services)

Background to St Mary Street Surgery

St. Mary Street Surgery is a semi-rural practice providing primary care services to patients resident in Thornbury and those living within a five mile radius. The practice has a patient population of approximately 6,750 of which 23.4% are over 65 years of age.

The practice has two male and one female GP partners. They employ a salaried GP, practice manager, four nursing staff and nine administrative staff. A number of these staff work part time. Each GP has a lead role for the practice and nursing staff have specialist interests such as diabetes, infection control and nurse prescribing.

The practice also provides training for doctors specialising in general practice.

Primary care services are provided by the practice Monday to Friday during working hours (8am-6.30pm). In addition there are a range of clinics for all age groups and specialist nursing treatment and support. The practice has opted out of the out of hours primary care provision. This was provided by another Out of Hours provider.

St Mary Street Surgery, in line with other practices in the South Gloucestershire Clinical Commissioning Group, is situated within a significantly less deprived area than the England average.

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

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

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

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

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

Detailed findings

Before our inspection, we reviewed a range of information we held about the service and asked other organisations, such as the South Gloucestershire Clinical Commissioning Group, the local Healthwatch and other healthcare providers to share what they knew.

We carried out an announced inspection on the 5 August 2014. During the inspection we spoke with two GPs, the practice manager, four nursing staff and administration staff. We spoke with 14 patients who used the service. We looked at patient surveys and comment cards.

We observed how staff talked with patients.

We looked at practice documents such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

Are services safe?

Our findings

Safe patient care

The practice used a range of information to identify risks and improve quality regarding patient safety. Staff used information from reported incidents and accidents, clinical audit and national patient safety alerts to inform practice. For example, changes to patients' medicines following safety alerts. The practice completed an annual complaints report in order to analyse and identify trends in the occurrence of complaints. All staff we spoke with were aware of how to report incidents.

Learning from incidents

The practice had a system for reporting, recording and monitoring significant events. There were quarterly meetings to review and share learning from the incidents. These were well attended by GPs and nurses who told us they were a useful forum for learning. We noted administrative staff did not attend even though some issues concerned administrative processes. However, minutes from the meetings were on the staff intranet for staff to review if they wished.

Records demonstrated changes to practice occurred when things went wrong. For example, the practice used a specific diagnostic blood test to identify heart conditions such as heart attack. The practice audited the use of the test as a result of three reported significant events. This resulted in a number of outcomes which at the time of the inspection were yet to be re-audited.

Safeguarding

The practice had systems to recognise and support patients who were at risk of abuse. There was an identified GP who was safeguarding lead, who had a clear role in supporting staff and overseeing the safeguarding process. Staff had ready access to the safeguarding policy for both children and adults for information and guidance. The policy included contact details of the appropriate authorities to report concerns.

Training records demonstrated nursing and administration staff were up to date with safeguarding training. However, we noted one GP's child protection training had expired and not all of the GPs had started safeguarding of vulnerable adults training in line with the provider's safeguarding guidance. In addition the safeguarding lead did not have level three safeguarding children training a recommendation for lead GPs. However, the staff we spoke with were aware of their roles and responsibilities with regards to protecting patients from abuse or the risk of abuse. They were able to recognise the signs of abuse and demonstrated how they would respond to safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This information was available on the patient's record so that staff were aware of any relevant issues when they attended appointments.

The practice worked collaboratively with other healthcare professionals to support children at risk and their families. Records demonstrated the Lead GP met monthly with health visitors to review child protection plans and feedback from other agencies involved.

The practice had a comprehensive chaperone policy as guidance for staff.

Monitoring safety and responding to risk

The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies. The emergency equipment included an automated external defibrillator, portable oxygen, ventilation equipment suitable for adults and children, manual suction and pulse oximeter (a pulse oximeter measures the level of oxygen in the blood). Staff we spoke with were aware of the location of emergency equipment and the procedure to manage an emergency.

Relevant emergency medicines were available to respond quickly in life threatening situations until an ambulance arrived. Records demonstrated staff checked emergency equipment monthly and the automated external defibrillator (AED) daily.

Medicines management

Patients were protected from the risks of unsafe medicine management. There was an identified medicines lead GP who had a clear role in overseeing risk management processes and ensuring quality.

We observed medicines were stored, checked and records maintained in line with legal and safety requirements. The practice kept a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). These were kept in a locked cabinet. Stock records were up to date and routinely monitored. The practice had completed a

controlled drugs self-assessment for 2014 which demonstrated 100% compliance with governance requirements. There was a comprehensive protocol for the management of and security of controlled drugs and staff were aware of these.

As part of stock control staff routinely checked and recorded the expiry dates of medicines held in the practice. Medicines refrigerators were secure and their temperatures were recorded daily to ensure medicines were stored under conditions which ensured their quality was maintained.

We found the procedure for repeat prescribing was in line with the practice policy and included measures to protect patients against medicine errors and abuse and the number of repeat prescriptions issued before a review was required.

In addition the practice had a system of audit of the use of medicines. We saw results from a range of prescribing audits undertaken in 2014 and found some patients' medicines had been changed in line with best practice or safety alerts. Prescribing errors were also discussed at significant event reviews.

Cleanliness and infection control

Patients were cared for in an environment which was clean and reflected current infection control practices. There was an identified infection control lead who worked with the practice manager to monitor the effectiveness of infection prevention and control measures. For example, the practice manager met with the external cleaning company on a monthly basis to review their cleaning audits of the practice which were part of the cleaning contract. The infection control audit completed in April 2014 identified some areas of improvement and were recorded in an action plan to address outstanding issues.

The practice was visibly clean, tidy, well lit and uncluttered. The treatment room had recently been refurbished in line with best practice guidance. For example, work surfaces were seamless and floors were coved to the wall to prevent the accumulation of dust and aid cleaning.

There were sufficient hand washing facilities for staff and patients. Staff had access to the personal protective equipment such as gloves and aprons when they needed it.

Staff had access to appropriate information about their role and responsibilities in protecting patients from the risk of infection. The practice had infection prevention and control policies as guidance and information for staff such as hand hygiene and the disposal of waste and other used equipment. Nursing staff were up to date with infection control training.

The practice had undertaken a legionella risk assessment and planned for the water supply to be tested in December 2014.

Staffing and recruitment

The practice had written guidance to support staff with the recruitment and selection process of new staff. Suitable candidates were asked to provide documentation to verify their identity and qualifications. These included references and proof of qualifications or registration with the appropriate professional body. GPs, nurses and administrative staff with chaperone responsibilities were subject to a satisfactory criminal records check via the Disclosure and Barring Service (DBS).

The practice had a system to enable sufficient staff numbers to meet service requirements. At the time of the inspection there were no staff vacancies. Staff told us there were usually enough staff to maintain the smooth running of the practice. They said team members worked well together. Part time working meant staff were able to increase their hours to cover staff absences. We saw from the staff rotas there was generally never more than one member of staff off from each of the teams. The GPs told us they preferred not to use locums and were able to cover colleagues sessions themselves.

Dealing with Emergencies

The practice had a comprehensive emergency plan to cover a range of situations which could disrupt the service provided.

The practice manager told us staff had not had a practical fire drill or evacuation training. However 86% of nursing and administrative staff were up to date with fire safety training. We noted the GPs had not received this training for some years.

Equipment

We saw from practice records that equipment was regularly serviced and maintained. Maintenance checks included the annual testing of all electrical equipment and fire protection equipment such as fire extinguishers. Practice fire risk assessments were reviewed every six months.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. Staff gave us examples which included the application of evidence based practice in the treatment of wounds such as compression bandaging for varicose ulcers. The use of National Institute of Health and Care Excellence (NICE) patient treatment pathways for managing long term condition such as diabetes and chronic respiratory disease.

Nursing staff we spoke with were confident in their understanding of their legal and ethical responsibilities for gaining informed consent prior to treatment. They described the importance of an assessment to determine for example, whether a child was mature enough to make decisions or for adults who may have had impaired capacity.

Vulnerable patients with long term conditions were assessed and started on a care plan to enable increased monitoring and follow up of patients.

Management, monitoring and improving outcomes for people

The practice had a system in place for undertaking clinical audit. Examples we looked at from the 2014 audit schedule, included the management of gout and the use of a diagnostic blood test for patients with chest pain. We saw from the medicines audit results changes had been made to patients' prescribed medicines in line with best practice. Recommendations from the audits had yet to be re-audited to demonstrate that the changes had been implemented and that improvements have been made.

Nursing staff gave examples of how they monitored the effectiveness of the treatment they provided. For example, to demonstrate wound healing they measured wounds and took photographs on a regular basis. They also used patient feedback as a qualitative measure of care.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The 2013/14 QOF results for the practice compared favourably with other practices in the area. Data from QOF was used to ensure appropriate health checks were offered to patients.

Staffing

Staff received training and support to undertake their role. Records demonstrated most staff had completed essential training such as basic life support and safeguarding training. Nurses told us they had study time and a study budget to update their knowledge and skills for their role.

Nursing and administrative staff did not have formal, documented performance reviews in line with the practice HR policy. However, staff told us they were well supported and worked well within their teams. They said practice and staff related concerns and issues were addressed on an informal basis as and when they arose or at monthly team meetings. We were given examples of how staff achievement was recognised through promotion and how nursing staff were supported to develop areas of specialist practice. We saw that staff performance issues were managed promptly and in line with the practice policy.

The GPs had an annual appraisal as part of their revalidation (a process to demonstrate they are fit to practice).

The practice had a recruitment policy and processes were in place to ensure patients were supported by suitably skilled, qualified and experienced staff. Records showed nursing staff were registered with their professional regulatory body the Nursing and Midwifery Council.

The practice had a comprehensive induction programme which was adapted to meet staff role responsibilities. Core components of the programme included reading of practice policy and procedures.

Working with other services

The GPs worked with other healthcare providers to co-ordinate and manage patients' care effectively. The GPs said there were two weekly care planning meetings with the community matron and community nurse with responsibility for older adults to review the care of patients with long term conditions.

The GPs provided primary care services to their patients resident in four local care homes. Patients in one home said they were generally satisfied with the care they received and the GPs met their specific health needs.

Community nurses, health visitors, midwives and community mental health nurses were not based at the surgery. The staff we spoke with from the multi-disciplinary team told us the GPs and nurses responded to patient

Are services effective?

(for example, treatment is effective)

concerns appropriately and generally communication with the GPs was satisfactory. Care plan meeting minutes confirmed patients were reviewed by the GPs and community matron and nurse for the older adult regularly. Outcomes from the meetings included starting care plans for vulnerable patients to enable increased monitoring and follow ups of patient admitted to hospital following falls. The GPs met monthly with the health visitor to review child protection cases.

Patients had timely access to secondary care services (secondary care services are provided by medical specialists and other health professionals who generally do not have first contact with patients for example hospitals). Most patients told us they were satisfied with how the practice managed referrals although from the 19 patient interviews and 14 comment cards three patients said they had not been referred when requested. Those patients who were satisfied with how the practice managed referrals gave examples of prompt and appropriate referrals to secondary services including hospital and psychological services. The practice administrators had a system to ensure urgent referrals were given priority.

Patients' blood and other test results were requested and reported electronically to prevent delays and reduce error.

GPs reviewed reports the following morning for patients seen by the out of hours service and followed up patients requiring further treatment. Significant event reviews demonstrated the GPs acted on out of hours providers feedback to improve communication between the services.

Health, promotion and prevention

Patients had access to a range of health promotion information in the surgery and on the practice website. The practice offered specialist clinics for patients with long term conditions such as diabetes and asthma where health promotion discussions were part of their treatment plan.

The practice offered clinics to support patients maintain a healthy lifestyle and improve their health such as a smoking cessation clinic.

The practice provided screening services such as cervical screening and blood pressure monitoring to enable the early detection of disease.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 14 patients of different age groups and looked at a range of written feedback from patients. Comments from 16 of the 19 patient comment cards and 12 of the 14 patients we spoke with told us they were satisfied with their care and treatment. Patients appreciated the helpfulness and politeness of staff. They said staff treated them with dignity, respect and kindness. Patients had also independently written many positive comments on a feedback sheet provided by the practice.

We observed staff were patient and kind in their interactions with patients and relatives and were supportive.

The practice waiting area did not enable confidentiality and privacy to be maintained. Conversations between receptionist and patients could be overheard by patients in the waiting room. The practice had an action plan and had started to address the concern. For example, there was a patient self-check in system away from the main reception which staff told us was to minimise congestion and promote privacy. Plans to relocate a telephone and work station to a room away from patient areas were underway.

Staff and patients told us doors, curtains and blinds were closed before starting treatment to maintain privacy and dignity. Staff said patients could ask if they wanted a chaperone (having someone accompany a patient during a consultation) however, there was no visible information available in the practice to inform patients of their rights. Administrative staff providing chaperone duties when nursing staff were not available, had the relevant security checks via the disclosure and barring service (DBS) and were awaiting training before they supported patients as a chaperone.

Involvement in decisions and consent

Patients told us doctors and nurses explained their care and they were involved in making decisions about their care and treatment. 83% of practice respondents to the GP National Patient Survey 2014 said GPs involved them in care decisions and 90% felt the GP was good at explaining treatment and results.

Nursing staff described examples of how patient choice was respected. For example, some patients were offered options of treatment for managing wounds to minimise disruption to their lifestyle and promote independence.

Patients had access to a variety of health information on display in the waiting area of the practice and also on the practice website. To improve communication for some patients the practice had access to translation services for people whose first language was not English. There was a loop system for patients with hearing difficulties. However, we noted there were limited alternative formats of information such as diagrams, models and easy read formats to enable informed choices.

Nursing staff were aware of their legal and ethical responsibilities for gaining informed consent prior to treatment. They understood how to enable patients to understand and make their own decisions. For example, staff stressed the importance of gaining trust, spending time explaining and checking patients' understanding, involving carers with the patient's permission. Nurses referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the main patient population they treated. The patient population had a higher than the national average population of over 65's.

Older adults had access to preventative services such as flu immunisations and screening services to detect and monitor the symptoms of certain long term conditions such as heart disease. The Quality and Outcomes Framework (QOF) national quality standards indicated the practice had scored 100% for the management of some conditions of the older adult for example, osteoporosis (weakened bones) and strokes.

The practice delivered an enhanced service (locally developed service over and above the essential/additional services normally provided to patients) for older patients. For example, the prevention of unplanned hospital admissions. The delivery of the service included the co-ordination and management of care of frail older patients and other high-risk patients. The practice demonstrated their achievement of this service by regular meetings with the community matron and nurse for the older adult, the development of patient care plans and the identification of the most vulnerable patients.

The practice had set up a virtual patient participation group (PPG) within the last few months to promote and support patient views and participation in the development of services provided by the practice. We were told by the practice manager the group had a membership of 135 patients and represented a comprehensive range of the patient population with regards to age, gender and health care needs. The nominated practice GP was working with the group to develop a patient questionnaire to collect patient feedback about the service.

The practice had made some adjustments to the building for patients with mobility needs such as a ramp to the door and a lowered reception desk for wheelchair users. However, the main door was not automated and there was no doorbell to summon help. We observed staff offered help when they were aware a patient needed to enter the building.

Access to the service

The service provided enabled patients to access the care they needed promptly and efficiently. The practice opened Monday to Friday 8am to 6.30pm and as part of an enhanced service late appointments were available every Monday between 6.30pm and 8pm. Early appointments were available alternate Thursdays between 7am and 8am. Patients were able to see a GP for an urgent appointment by attending the practice after 11.15am or they were offered a telephone consultation. We noted the information regarding extended hours was in the practice leaflet but not on the practice website for patients not wishing to attend the practice for the information.

Patient feedback on the day and data from the annual GP National Patient Survey 2014 indicated patients were able to get an appointment when they requested. However, contacting the practice by telephone during peak periods involved long waiting times. In response the practice manager had introduced electronic booking of appointments and email contact to ease congestion of the telephones. Patient feedback we received suggested this was proving effective.

Patients were asked simple health related questions by the receptionists at the point of making an appointment. Receptionists checked with the GP whether some patients could be offered an appointment with the lead nurse who was appropriately qualified to provide treatment and support for minor illnesses. The practice manager told us patients could choose to see the doctor rather than the lead nurse.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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.

There had been four written complaints in 2014. They were managed in line with the practice policy and did not demonstrate a trend in the concerns patients raised. The practice had addressed the issues to avoid a recurrence. For example, providing extra training.

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us they were not familiar with the procedure for making a complaint. However, they said they would not hesitate to speak to the GP or practice manager if they had concerns. We saw information regarding making a complaint was available in the practice and practice leaflet.

Are services well-led?

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

Our findings

Leadership and culture

The practice vision and values emphasised the importance of reflecting traditional values of being a personal, friendly, patient centred and education led practice. This was reflected in staff values. Staff we spoke with gave examples of how knowing their patients, some over many years enabled effective care and treatment.

Staff told us they enjoyed working in the practice and were well supported by the GPs and other staff.

We found practice systems and processes were transparent and promoted staff inclusion and participation. There were regular meetings for all staff to raise awareness of practice issues.

Governance arrangements

Staff were aware of their roles and responsibilities for managing risk and improving quality. Each service area had a department lead to develop their service and manage their staff. GPs and senior members of nursing and administrative staff had lead responsibilities for example safeguarding, clinical governance and carers services.

The GPs met weekly with the practice manager and all other staff met monthly within their own teams to discuss practice issues, developments and performance standards. In addition the GPs and nurses met quarterly to review significant events, share best practice and discuss complex case management.

Systems to monitor and improve quality and improvement

The practice had systems to reduce risk and improve the quality of the service. Staff were committed to demonstrating the care and treatment provided met the Quality Outcomes Framework (QOF) nationally recognised quality standards. The practice held regular QOF meetings with GPs and nurses and identified areas for improvement such as monitoring of high blood pressure. The practice achieved high scores in the Quality and Outcome Frameworks audits (QOF) and compared favourably with other practices in the area.

The GPs were engaged in a programme of clinical audit and service improvement for example, the management of gout, regular medicines audit and infection control audit.

At the time of the inspection, recommendations from the 2014 clinical audit cycle had yet to be re-audited to demonstrate that the changes have been implemented and that improvements have been made.

Patient experience and involvement

The practice used a variety of strategies to collect patient views on the services it provided and the practice acted on feedback it received. Patient views were collected via the GP National Patient Survey, a suggestions box in the practice and an email address for contacting the practice, which was on the practice website. Plans to relocate a telephone to a room away from the reception area to ensure conversations protected patient privacy and confidentiality was influenced by patient feedback.

The practice had set up a virtual patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. We were told the group had a membership of 135 patients and represented a comprehensive range of the patient population. The practice manager told us the nominated practice GP was working with the group to develop a patient questionnaire to collect patient feedback about the service.

Staff engagement and involvement

Staff were engaged informally and formally with practice issues. They told us they could raise ideas for improvement or concerns with their team lead who reported at the weekly practice meetings. Nurses attended the quarterly clinical meetings. Meeting records demonstrated their suggestions resulted in changes to practice such as, increased time allowed for a specific respiratory function test. Meeting minutes were available on the staff intranet.

Learning and improvement

The practice showed a strong focus on learning. GPs and nurses were encouraged to update and develop their clinical knowledge and skills. The practice provided training for doctors specialising in general practice and two of the practice GPs were trainers.

The practice enabled dedicated study time and financial support for education and training for nursing staff as part of their personal development plan.

Staff did not have a documented performance appraisal. Staff told us they met formally and informally with their team lead to discuss performance, concerns and personal development goals. This was confirmed by staff records

Are services well-led?

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

which demonstrated staff achievement was recognised through promotion, staff had attended training courses to enhance their role and staff performance was managed promptly and in line with the practice HR policy. The practice had begun to address the issue and had commenced a schedule of documented staff appraisal.

Identification and management of risk

The practice had a system to evaluate significant clinical events and incidents. Staff met regularly to review these events. Records demonstrated there had been changes to practice such as the use of a specific diagnostic test and the monitoring of the side effects of some medicines.

GPs and nurses responded to national safety alerts and used audit to identify patients at risk. The records demonstrated changes in practice for example, amendments to prescribed medicines.

The practice had a robust system to evaluate patient complaints and significant clinical events. For example a significant event review led to an audit of prescribing a diagnostic blood test for chest pain.

The practice had a comprehensive business continuity plan to enable the practice to maintain a service in the event of an emergency.

Older people

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

Our findings

The practice supported older patients by enabling easier access to services without having to attend the surgery. For example the facility to book an appointment and request a repeat prescription via the internet.

Patients were invited for an annual flu vaccination and a one off shingles vaccinations.

The Quality and Outcomes Framework (QOF) national quality standards indicated the practice had scored 100% for the management of conditions of the older adult for example, osteoporosis (weakened bones) and strokes.

The practice delivered an enhanced service to co-ordinate and manage the care of frail older people to avoid unplanned admissions to hospital. The practice demonstrated their achievement of this service by regular meetings with the community matron and nurse for the older adult, the development of patient care plans and the identification of the most vulnerable patients.

GPs conducted home visits to patients in their own homes or in local nursing homes. Feedback from one home indicated patients were satisfied with the care they received.

People with long term conditions

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

Our findings

The practice supported patients with long term condition such as diabetes and respiratory disease by offering advice, education and treatment through specialist clinics. The clinics were led by nurses who had achieved specialist qualifications and were able to offer additional services such as prescribing and diabetes management.

There were regular care planning meetings with the community matron and staff nurse with responsibilities for the older adult to review the treatment and support of vulnerable patients with complex and life limiting long term conditions. The most vulnerable patients had a personalised care plan including details such as their preferred place of care and an agreed plan for escalating care, including crisis management. It was anticipated that the regular review of this group of patients would reduce the risk of hospital admission.

The Quality and Outcomes Framework (QOF) national quality standards indicated the practice had scored between 99% -100% for the monitoring and management of the ten long term conditions identified.

Mothers, babies, children and young people

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

Our findings

The practice supported mothers, children and young people by working with other healthcare providers to provide maternity services. The practice worked collaboratively with other healthcare professionals to support children at risk and their families. Records demonstrated the Lead GP met monthly with health visitors to review child protection plans and feedback from other agencies involved.

Immunisation clinics were led by appropriately qualified and trained nurses.

The nurse practitioner saw patients over the age of five years for minor ailments.

The practice delivered an enhanced service (a locally developed services over and above the essential/ additional services normally provided to patients) to promote sexual health. This mainly included contraceptive services and sexually transmitted disease screening.

The practice website included useful links to other services for young people such as teenage health and sexual health advice.

Working age people (and those recently retired)

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

Our findings

The practice provided screening services for adults between the ages of 40 and 75. This enabled the early detection of medical conditions such as diabetes, respiratory conditions and high blood pressure. Specialist clinics for example, diabetes provided on-going information, monitoring and support for patients with an existing condition or the newly diagnosed.

Patients had access to a smoking cessation clinic held at the practice. The practice website had links to further information and organisations.

The practice provided additional appointments (Monday 6.30pm – 8pm and alternate Thursdays 7am – 8am) outside working hours (9am – 5pm) to meet the needs of working people.

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

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

Our findings

The practice had facilities for patients requiring support with communication. There was access to a translation service for patients whose first language was not English. There was a loop system in the reception area for patients with hearing difficulties. However the design of the building did not enable patients with mobility needs to gain access without assistance.

The practice provided annual health checks for patients with learning disabilities. The practice provided primary care services to a care home for some patients with learning disabilities. Patient feedback indicated patients were generally satisfied with the support they received.

GPs were working with the community matron and community nurse for the older adult to develop care plans for patients with dementia.

People experiencing poor mental health

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

Our findings

The practice had started care plans for patients experiencing poor mental health. Quality data demonstrated the practice compared favourably with other practices in the assessment of depression.

The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions.

The practice website included useful links to other information and support services.