The Symons Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of the Symons Medical Centre on 11 March 2015. We have rated the practice overall as Good. The practice was rated good in all five domains.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Risks to patients were assessed and well managed.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure all appropriate staff have chaperone training.

Ensure appropriate systems are in place to document clinical meeting discussions.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Feedback on the access of appointments was mixed. Some patients were satisfied with appointment system. They told us they were happy to see another GP if there was a wait to see the GP of their choice. However, some patients told us they found it very difficult to make a routine appointment. The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over 75 had a named GP. The premises and services had been adapted to meet the needs of people with mobility problems. We saw that the waiting area and treatment rooms were able to accommodate patients with wheelchairs. Accessible toilet facilities were available. Patients had access to onsite pharmacy. The practice offered to deliver patients medicine delivered to them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice offered services such as spirometry, phlebotomy and ECGs on site, which meant patient had greater flexibility to use these services. The practice worked closely with district nursing team and held monthly palliative care meetings. The practice had access to local retinal screening and dietetics services, and made appropriate referrals for patients when required.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

The community midwife held regular antenatal and post natal clinics onsite. The practice offered obstetric care to all pregnant women. This involved, routine 10 days post-partum contact and a

Summary of findings

dedicated liaison midwife. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

The practice had a high proportion of patients with learning disability. For these patients they offered home visits to deal with medical needs and for influenza vaccinations. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Weekly health reviews were offered to patients who were alcohol and drug dependent. These patients prescribed on weekly basis to ensure safe prescribing. The practice worked closely with agencies such as local SMART team.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Planned reviews were carried out for all patients with mental health needs.

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

Summary of findings

What people who use the service say

We spoke with seven patients on the day of the inspection. Patients we spoke with were very positive about the service they received from the practice. Patients described staff as caring, kind and compassionate. Feedback on the access of appointments was mixed. Some patients were satisfied with appointment system. They told us they were happy to see another GP if there was a wait to see the GP of their choice. However, some patients told us they found it very difficult to make a routine appointment.

Patients told us they felt involved in their care and treatment and the doctors explained their health care needs in a way they could understand. Patients said they were given a wide range of information about their medical condition by the GP or the nurse. Patients told us they felt safe when attending the surgery and were confident of the conduct of the GPs and nurses.

We received further feedback from 32 patients via comment cards. The comments cards reviewed were generally positive. Patients described staff as friendly, accommodating and supportive.

Patients commented GPs and nurses explained procedures in great detail and were always available for follow up help and advice.

The practice results for the national GP patient survey 2014 were within the clinical commissioning group (CCG) and national average. Eighty five per cent of patients said they were able to get an appointment to see or speak to someone the last time they tried. Ninety four per cent of patients said the last appointment they got was convenient and 96% of patients said they had confidence and trust in the last GP they saw. Eighty eight per cent of patients described their overall experience of this surgery as good.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all appropriate staff have chaperone training.
- Ensure appropriate systems are in place to document clinical meeting discussions.

The Symons Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector, and a GP specialist advisor. The team included an expert by experience.

Background to The Symons Medical Centre

The Symons Medical Centre was founded in 1920 and have been providing medical services to patients in Maidenhead since then. The practice occupies the current purpose built health centre, since 1991. The premises had been renovated over years, to meet patient requirements. The practice provides primary medical services to over 12,000 patients in Maidenhead, Berkshire. The Symons Medical Centre has a high proportion of elderly patients. Consultation and treatment rooms are spread on the ground.

Care and treatment is delivered by four male GPs, three practice nurses, two health care assistants and two phlebotomists. The practice also works closely works with district nurses, midwives and health visitors. Outside normal surgery hours patients were able to access emergency care from an Out of Hours (OOH) provider. Information on how to access medical care outside surgery hours was available on the practice leaflet, website and waiting area.

The practice has a Primary Medical Services (PMS) contract. PMS contracts are negotiated locally with the local office of NHS England.

There were no previous performance issues or concerns about this practice prior to our inspection.

The practice provides services from:

The Symons Medical Centre

25 All Saints Avenue

Maidenhead

Berkshire

SL6 6EL

Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback.

Detailed findings

This included information from the clinical commissioning group (CCG), Reading Healthwatch, NHS England and Public Health England. We visited The Symons Medical Centre on 13 March 2015. During the inspection we spoke with GPs, nurses, the practice manager, reception and administrative staff. We obtained patient feedback by speaking with patients, from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice had some systems in place to identify risks and improve quality in relation to patient safety. This was achieved through reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice had not raised any safeguarding alerts within the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. For example, we saw one significant event has been raised in relation to a prescription error. The findings and learning was discussed with the clinical and reception team.

Significant events were discussed during weekly clinical meeting and a dedicated meeting was held every monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager via email to practice staff. Staff also told us that safety alerts were discussed at weekly practice clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, acted as chaperones. We found the staff had not received chaperone training. The practice manager showed us evidence they had made enquiries about chaperone training and had planned to provide chaperone training to all appropriate staff.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Vaccines were stored and transported safely. Vaccines were stored in fridges which staff checked regularly. Expired and unwanted medicines were disposed of in line with waste regulations.

Good

Are services safe?

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Information about who was eligible for flu vaccination was displayed in the waiting room on the practice website.

The GPs were responsible for prescribing medicines at the practice. The control of repeat prescriptions was managed well. Prescription scripts were kept secure when not in use. Patients were not issued any medicines until the prescription had been authorised by a GP.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a cleaning schedule in place. This was monitored by the practice manager and infection control lead.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw staff had received infection control training. We saw evidence that the lead had carried out an infection control audit in March 2014, and any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with 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 bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was November 2013. A schedule of testing was in place. We saw a log of calibration testing for the practice and all equipment was calibrated in November 2013.

Staff we spoke with knew the location of the resuscitation equipment. We saw evidence staff had received training in basic life support. Health and safety, first aid and fire evacuation procedures were available in the staff handbook.

Staffing and recruitment

We reviewed one staff personnel file, for staff who had been recruited in the last two years. We saw evidence that appropriate recruitment checks had been undertaken prior to employment. We saw evidence of references and recent photograph. The practice had obtained evidence for staff to ensure they were physically and mentally fit to carry out their roles. We saw evidence and criminal records checks through Disclosure and Barring Service (DBS) were in place for appropriate staff.

The practice manager told us a Curriculum Vitae (CV) was received and used to discuss in the interview and identity checks were completed, however this information was not kept onsite and was not available for us to review on the day of the inspection.

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 that enough staff were 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 keep patients safe.

Monitoring safety and 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 checks of the environment,

Good

Are services safe?

medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw evidence that the practice had completed some risk assessments. These included, risk assessment of fire, infection control and legionella. Any risks were identified and action plans were put in place to minimise risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. At the time of the inspection the practice did not have access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). However, following the inspection the practice manager confirmed to us the practice had decided to keep a defibrillator and that one had been purchased. We were sent evidence to confirm this.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GP partner told us new guidelines were disseminated and discussed informally and during team meeting, and required actions agreed. The GP also signed up to a mobile application, where they received updates on all new clinical guidance, on a regular basis. Any changes were then shared with the practice team. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The practice had an organised system in place for completing clinical audit cycles. We saw several examples of two audits which had been carried out and the practice could demonstrate that they had improved outcomes for patients over time. These included audits for dermoscopy, Ear, Nose and Throat (ENT), warfarin, Hormone Replacement Therapy and orlistat audits. For example; we reviewed the combined oral contraceptive (COC) audit. In response to the audit findings the practice reviewed and changed its protocols. We saw evidence that key points had been summarised and learning was shared with staff.

The practice routinely collects information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice achieved 98% on their QOF 2014 score compared to a national average of 96%. We saw the practice did well in clinical areas, such as depression, heart failure and epilepsy.

The practice manager closely monitored performance every month and shared with the clinical team the performance levels and highlighted areas that needed improving throughout the year. For example, in 2013/14 we saw 95.83% of patients with mental illness had received an annual review of their health. The practice had recall systems for patients and these included using letters and phone calls to remind them to book a review."

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

All GPs had undertaken regular annual appraisals and either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) GP continue to practice and remain on the performers list with NHS England).The nursing team had been appraised annually. Staff told us the practice was

Good

Are services effective?

(for example, treatment is effective)

proactive and supportive in providing training that been identified. For example, one of the nurses had completed NQF level 5 qualifications in asthma and chronic obstructive pulmonary disease (COPD).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the GPs and nurses on a regular basis.

The practice was keen to ensure all staff members were upskilled to enable them to do new roles and expand their capabilities. For example, the administrative staff had been trained in phlebotomy, electrocardiography, spirometry and audiology services. This ensured better accessibility to patients for these services. This also freed up the nursing team to concentrate and deal with patients who had complex health issues.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were aware of their responsibility in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. GPs told us they, also invited the district nurses to the weekly clinical meetings. The GPs regularly communicated with the district nurses about patient care planning and needs, via email and shared important information. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

There was a practice policy for documenting consent for specific interventions. For example, for all medical treatment, immunisations, investigations or an operation. In these case a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The GPs and nursing staff had a sound knowledge of the Gillick competency considerations, when dealing with young patients. Gillick competence is used to decide whether a person (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental consent or knowledge.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

A range of literature was accessible in the practice waiting room and on the practice website aimed at supporting health promotion and self-care. For example, the practice website provided information on family health, minor illness, sexual health and long term conditions. GP has referred patients to the most appropriate support group. The practice signposted patients to other local services, such as dental services and local hospitals.

It was practice policy to offer all new patients a health check. New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, post or hand into the reception team. The healthcare assistant carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems.

The clinical staff we spoke with told us they promoted health information through consultations. This was done by providing leaflets or providing information from the internet.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

In 2013/14 the number of patients with a smoking status recorded in their records was 91.39% which was higher than the CCG and England average. Of these patients 97.61% of patients had received advice and support to stop smoking which was also higher than the national and CCG average.

In 2014 the practice vaccinated 64.1% of patients over 65 years old with the flu vaccine. This was lower than the national average of 72.99%. For patients within the at risk groups, 37.89% of patients were vaccinated in the same period. This was lower than the national average of 53.22%. The practice was aware of this, and told us they had found it challenging to get these patients vaccinated. In order to improve in this area, the practice had discussed to have more vaccination clinics and to introduce a text service. The practice had planned to collate data for 2015 and analyse whether improvements have been made.

The practice offered screening services for patients. Eighty one per cent of eligible women received a cervical screening test in 2014. This was higher than the national average of 77.08%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and practice surveys. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the latest national patient survey 2014 showed that 88% of patients said that the GP they saw was good at treating them with care and concern. Ninety six per cent of patients said they had confidence and trust in the GP they saw. Eighty seven per cent of patients said the nurse they saw was good at treating them with care and concern and 99% of patients said they had trust and confidence in the nurse they saw.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a visible notice in the patient leaflet and on the practice website stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 that 90% of patients said the last GP they saw was good at listening to them and 75% of patients said the GP they saw was good at involving them in decisions about their care. Eighty four per cent of patients stated the nurse they saw was good at giving them enough time and 87% patients said was good at listening to them. The number of patients who stated the GP was good at explaining tests and treatments was above average for the CCG.

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.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access 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.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw information on bereavement support was available on the practice website. This included support available to the relatives of the deceased, if the death occurs at home or at the hospital. One patient commented, during a recent bereavement of a relative, all practice staff had treated them with empathy and were very supportive during a difficult time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had approached a local pharmacy to join them on site. The pharmacy agreed to this arrangement and in order to facilitate this service the practice had reconfigured the premises. This ensured the pharmacy service was accessible and convenient for all patients.

The practice introduced a health programme. The practice ran a 12 week trial, whereby overweight patients and 'pre-diabetic' patients were referred to their nutrition and health course. The clinician used clinical methods to assess blood sugar, body fat and cholesterol, as well as weight loss, to provide an overall picture of health. Once this information was collated the GP or nurse referred the patient to appropriate organisations for support. This meant patients benefited from early detection of diseases such as diabetes, and were able to obtain preventative advice, education, care and treatment in a timely manner. In 2014, the emergency long term conditions admissions rate for the practice was 19.93% which was lower than the CCG and England average.

The Windsor and Maidenhead (WAM) CCG have the highest number of nursing and care home patients of all England CCG's. The Symons Medical Centre look afters the highest proportion of these patients. To meet the needs of these patients the practice worked closely with the Windsor and Maidenhead CCG and was involved in care project to ensure care was delivered safely and effectively and to reduce harmful hospital admissions. In 2013/14 the A&E rates for the practice were 48.8%, this was significantly lower than national average of 82.26%.

A range of clinics and services were offered to patients, which included child health surveillance, contraception, cervical smears, mammography and maternity medical services. The practice ran regular nurse specialist clinics for long-term conditions. These included asthma, diabetes, coronary heart disease (CHD) and baby immunisation clinics.

Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with long term condition on practice register and organised recall programmes accordingly. The practice had reconfigured its systems for diabetic patients, to allow all diabetes patients to have blood takings and test results at the same time.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. For example, the practice discussed with the PPG the provision of extended hours, and whether access through these hours should be provided in the evening or early mornings. Both practice and the PPG agreed to provide the extended service by offering early morning appointments, allowing patients access to pharmacy or any investigations required on the same day if necessary.

The practice had also taken appropriate action, where necessary, to ensure they met patient's needs. For example, the choose and book system had caused the practice many problems. One of the GP partners wrote to MP Theresa May and raised concerns of the patient directly with them. In response, the MP visited the practice and attended a team meeting and through discussion the issues with the choose ad book system were resolved. The leading GP partner told us all other local practices also benefited from this. We also saw evidence the practice had contacted the local Clinical Commissioning Group (CCG) to improve the blood taking process for dementia patients and worked with CCG to ensure better care was provided for these patients.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of people with mobility problems. The practice had a car park with disabled parking and adapted toilet and washroom facilities for patients with disabilities. The practice was accessible to patients with mobility difficulties. All the treatment and consultations rooms were on the ground floor. The practice had access to an efficient translation service should patients require it. The reception staff told us patients decided what was urgent which ensured there was no barrier to receive care and support from the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients who lived in isolated circumstances and found it difficult to travel to the practice were able to book a home visit appointment and were seen by a GP in their home. We saw records showing the allocation of appointments available each day for the week of the inspection.

Staff told us that if a homeless person attended the practice and required immediate care they would be treated at the practice. However if care required was not immediate, they would refer them to a local practice which registered homeless people.

Access to the service

Appointments were available from 8am to 6.30pm on Mondays and 7am to 6.30pm from Tuesday to Friday. Patients were able to book appointment to see a GP or nurse by telephone, online and in person. Patients were able to book a double appointment by choice or when requested by the clinician. Patients were able to request repeat prescriptions and appointments online.

Telephone access was available during core hours and patients were triaged for appointments. During telephone consultations GPs dealt with a combination of patient queries including, health advice, results discussions and medical triage.

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 through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP and to those patients who needed one.

Feedback from patients we spoke with on the day of inspection about the appointment system was mixed. Some patients were satisfied with appointment system. They told us they were happy to see another GP if there was a wait to see the GP of their choice. However, some patients told us they found it very difficult to make a routine appointment. Patients we spoke to confirmed that they could see a GP on the same day if there was an emergency.

Comments received from patients via the comment cards showed that majority of the feedback on the appointment system were very positive. Many patients said they were able to get an appointment with GP or nurse easily. Patients confirmed that they could see a doctor on the same day if they needed to. Some patient commented they felt they were lucky to with such practice. Another patient commented they had changed to The Symons Medical Centre practice for this reason; the practice had a good reputation in relation to patients being able to obtain an appointment.

Patients benefited from a stable staff team because staff retention was generally high, which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments and there was an effective triage system in place.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided in the waiting area and on the practice website and leaflet. This allowed patients to make an anonymous complaint as they were able to provide the information discreetly.

The complaints procedure provided further information on how to make complaint on someone's behalf and who at the practice would deal with the complaint.

The practice kept a record of all written complaints received. The complaints we reviewed had been investigated and responded to, where possible, to the patient's satisfaction.

Patients we spoke with told us they would speak with their GP or the practice manager should they need to make complaint. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. The practice vision was to provide appropriate and rewarding experience for all patients who required medical support. The practice values included openness, fairness, respect and accountability.

The practice vision included supporting patients to manage their lives in their own community setting, when discharged from hospital. The practice had planned to offer residential units onsite. This would include self-contained units, with sleeping area, ensuite bathroom, a small seating area and communal kitchen. An extra unit would also be built to allow for overnight carer.

The aim of this project was to help unblock hospital beds, help transform patients' lives by integrating them back into their home life more quickly by supporting and building confidence. The patient's family and friends would be encouraged to visit and support ongoing progress, which would improve the patients' mental wellbeing.

This would be achieved by reconfiguring the current premises and working closely with the social care team, local authority, community services and CCG. The practice research showed, if they were successful in offering this service to patients, this would considerably reduce the cost of 'bed blocking' to the NHS. At the time of the inspection, the practice had applied for improvement grant from NHS England, and were awaiting outcome.

All staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. A GP partner told us that the strategy for the future development of the practice included recruiting new GP's and establishing new GP partners and expansion of current premises to ensure the practice could continue to deliver high standards of care and treatment to all patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

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

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and nurses had lead roles in clinical areas such as asthma and diabetes. GP lead roles included safeguarding, training and palliative care. All staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

During our inspection we found the practice did not minute some of meetings that took place. We saw evidence the practice manager made some notes of the discussions that took place in clinical meetings and recorded this in a book, but did not have an appropriate system to minute these meetings so these could be cascaded to all staff.

Leadership, openness and transparency

The practice business plan described the management style as functional and informal. The management team told us they had developed a stress-free, relaxed and lively culture, which encouraged all staff to remain focused and project a positive attitude to patients. This was supported by the staff we spoke with. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as disciplinary procedures, induction policy, and management of sickness and saw these were in place to

Are services well-led?

Good

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

support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had a patient participation group (PPG), where initially nine members attended. PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. The PPG had comprised of retired patients, carer, working people, and patient with a disability. There was also a virtual PPG of approximately six members who the practice made contact with regularly to involve in decisions about the running of the practice.

The practice manager told us the group was no longer active, as some members had passed away and others had left the group. We were told the practice was keen to get the group started again and had advertised for new members. Some new patients had shown interest to join the group.

The practice had identified it was difficult to get teenagers and working age people involved and were looking at different ways to attract these patients. For example, the practice had discussed the option of setting up a social media page to engage young patients. We saw evidence the PPG had advertised information on how to join the group on the practice leaflet and website and in the waiting area.

The practice manager told us the practice valued the previous PPG's input and their views were listened to. We were given examples of where the PPG had highlighted areas where PPG feedback was acted on and changes were made. For example, the PPG were instrumental in securing disabled parking for patient's onsite. In addition, the PPG had suggested the practice should hold mid-day GP clinics and this was reviewed and acted upon. Patient feedback showed the mid-day clinics were well received by patients.

Staff told us they felt involved in the running of the practice. They told us they were encouraged to share ideas for best practice and there suggestions have been acted upon

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was supportive of training. For example, on member staff had requested further training in choose and book system and this had been provided by the practice.

The practice had completed reviews of significant events and other incidents which included lessons learned. We saw evidence that significant events were discussed at practice meetings and the lessons learned were shared with staff to ensure the practice to ensure the practice improved outcomes for patients.