Rother House Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Rother House Medical Centre on 31 March 2015. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of patients and the care and treatment they provided to their patients.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had an established and well trained team with expertise and experience in a wide range of health conditions.
- The practice had a clear vision which had quality and safety as a high priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

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 report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. We saw evidence the practice had made changes to procedures following incidents. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. This included the local Myton Hospice for patients who received palliative care. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Patient survey results demonstrated patients were satisfied with the care they received from the practice. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent

Summary of findings

appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. One GP partner was a member of the CCG board and a practice nurse was associate medical director of Community Services at South Warwickshire Foundation Trust (SWFT). Learning from these roles was used to improve the service offered to patients at the practice.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The practice had developed a five year plan. This anticipated the needs of the local population, an increase in patient numbers and patient expectation and the context of the practice within the political landscape. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. Staff had received inductions, regular performance reviews and attended staff meetings and events. Minutes of staff meetings needed to consistently record decisions taken and identify staff responsible for completing actions. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. Care plans were also in place for these patients. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. At the time of our inspection, the practice had just completed delivering its flu vaccination programme. The practice nurse had arranged to do these at patients' homes if their health prevented them from attending the clinics at the practice. The practice cared for patients within two local care homes and within the Nicol Unit (primarily for elderly care) located within Warwick Hospital. Care home patients included some newly discharged from hospital for which the practice had entered into a pilot scheme with South Warwickshire Clinical Commissioning Group (CCG).

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD). Health screening was also carried out for bronchiectasis, coeliac disease and diabetes Members of the GP and nursing team at the practice ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits. Patients told us they were seen regularly to help them manage their health. At the time of our inspection, the practice had just completed offering flu vaccinations to people with long term conditions. Practice nurses each had a specialism in a range of long term medical conditions. The practice was part of a GP 'buddy group' for long term medical conditions which shared best practice.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the South Warwickshire Clinical Commissioning Group (CCG).

Summary of findings

Weekly antenatal and baby and children's clinics were held. The practice provided cervical screening and a family planning service. A practice nurse was trained in contraceptive implant insertion and removal.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours on two evenings every week until 8pm and on alternative Saturday mornings for patients unable to visit the practice during the day. Practice nurse appointments were also available until 6.30pm on three days each week. NHS health checks were carried out for patients aged 40-75. Smoking cessation support was provided.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. Regular reviews were carried out in conjunction with community nurses and the practice had strong links with social services. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register so that the patients could be identified. All patients with learning disabilities received an annual health check at home. This included discussion with the patient's carer, for which appropriate consent was obtained. Staff were aware of safeguarding procedures and GPs told us how alerts were placed on the records of potentially vulnerable patients. The practice cared for patients within the Nicol Unit (primarily for elderly care) located within Warwick Hospital.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff worked closely with the community mental health team, consultant psychiatrists and social services staff. These teams worked with the practice to identify patients' needs and to provide patients with support, information and counselling. This included referrals for drug and alcohol dependency and for the NHS counselling service.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 20 CQC comment cards patients had filled in and by speaking in person with eight patients. Two patients we spoke with were involved with the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

All patients we spoke with and received comment cards from, were very complimentary about Rother House Medical Centre. Patients said GPs and practice nurses treated them with dignity and respect, were professional and courteous at all times and gave patients the time they needed. Patients also told us practice staff were always helpful and friendly. Eighteen patients told us the practice was friendly and welcoming. Eight patients commented on the high standard of cleanliness within the practice.

Some patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the 2014 practice patient survey showed that the practice scored above average within the South Warwickshire Clinical Commissioning Group (CCG) for satisfaction with the practice.

Most patients also said they were usually able to obtain appointments with ease and could usually get through to the practice on the telephone without difficulty. Some patients told us they would happily recommend the practice to friends and family members.

Rother House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor.

Background to Rother House Medical Centre

Rother House Medical Centre is located in Stratford town centre, next to the railway station. The practice

was formed in 1937 and moved to its current purpose built location in 1976. Since then, the practice has expanded to include a dispensary for practice patients who live over one mile from the surgery and a commercial retail pharmacy. There is also a branch surgery at the Rosebird Centre, on the opposite side of Stratford town centre. This is located within a Waitrose supermarket. We did not inspect the branch surgery on this occasion.

The practice, including the branch surgery, has 13,200 patients registered. Patients can be seen at either location. The area has a high elderly population and most patients speak English as their first language, including a large Polish community served by the practice. There is also a traveller community registered at the practice. Locally, unemployment is below the national average.

Rother House Medical Centre offers a range of NHS services including NHS health checks, family planning, well-woman, baby clinic, smoking cessation, weight and cholesterol monitoring. It is also a training practice and regularly hosts trainee GPs. Apprentice administrative staff were also employed and were provided with full training for a range of administrative roles.

The practice has eight GP partners, three salaried GPs, (GPs are male and female) six practice nurses, four healthcare assistants, four dispensary staff, including the manager, a practice manager, assistant practice manager and a team of administrative and reception staff. The practice has a General Medical Services (GMS) contract with NHS England. This is a standard contract for providing GP services.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered before the inspection we had no specific concerns about the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas above average with the England or Clinical Commissioning Group.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services provided by Care UK Warwickshire which they can access by using the NHS 111 phone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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.

Detailed findings

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 this inspection, we reviewed a range of information we held about Rother House Medical Centre and asked other organisations to share what they knew. These organisations included South Warwickshire Clinical Commissioning Group (CCG), NHS England local area team and Healthwatch. We carried out an announced inspection on 31 March 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with eight patients who used the service, two of which were members of the Patient Participation Group (PPG).

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

A range of information was used by the practice to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns, and discussed how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last three years. During this time, 58 incidents had been reported. These included patient diagnoses, medication errors and near misses.

Our examination of incidents showed the practice had managed them consistently over time and could show evidence of a safe track record over the longer term. It was practice policy to discuss every significant event at the next staff meeting. We saw evidence that discussions included an explanation of what happened, why it had happened, what action was taken and what the practice had learned from it. Any necessary changes were implemented and a date set to review them to ensure the changes were working effectively. Details of any changes in procedure were given to all staff and clearly displayed on the staff notice board. After the incident was reviewed, a decision was taken to either close the incident if any changes made were clearly working, or set a further review date if further analysis was needed.

For example, we examined an incident where details of prescriptions were added to the wrong patient notes. This was noticed when a pharmacy delivered the medicines to a care home. As soon as the error was discovered, the correct medicines were ordered for the correct patients and were immediately sent to a local pharmacy for dispensing and delivery. The practice introduced an extra level of checking the names, addresses and medicines on prescriptions.

We were also shown records that demonstrated information gained from other sources such as clinical audits and health and safety audits was assessed with patient safety in mind. For example, when Tramadol, a painkiller, was re-classified as a controlled drug in June 2014, the practice had placed restrictions on its issue to ensure it was only prescribed for short term and intermittent use and was not prescribed to patients who received other strong pain killers

Learning and improvement from safety incidents

There were systems in place for reporting, recording and monitoring significant events, incidents and accidents. This included a significant events protocol. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events and complaints were discussed at the next practice meeting. 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.

We examined the system used to manage and monitor incidents. We tracked a range of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken when a patient received a letter in error to advise them of an appointment for the anti-coagulation (blood thinning) clinic. When the practice investigated this, it was found a consultant's letter had been scanned onto the wrong patient's notes which had caused an incorrect referral to the clinic to be made. The correct patient had already been seen by the clinic. The practice contacted the patient by telephone and they were given an explanation and an apology. The anti-coagulation clinic was also informed. Patient notes were corrected and an action point was created to double check patient details when letters were scanned onto patient records. Administrative staff were also to raise any backlog of scanning with the practice manager. Throughout our examination of incidents, we saw when patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with practice policy.

We saw how national patient safety alerts were discussed in staff meetings with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. One such example concerned a medicine for diabetes. A safety alert had been issued warning that some batches may have contained too little or too much insulin. The practice searched for patients who have been affected and found 54. GPs went through the list and identified any patients who may have been at risk. The list was also circulated to the on-site dispensary and pharmacy. The practice took prompt action and re-issued four prescriptions the same day.

Good

Are services safe?

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 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 for relevant agencies were easily available to staff. Policies for safeguarding children and vulnerable adults were based on those issued by the safeguarding team at Warwickshire County Council. The practice used an 'abuse checklist' to ensure all actions had been correctly completed.

The practice carried out regular safeguarding audits to ensure procedures and contact details were up to date. Safeguarding concerns were discussed at the monthly multi-disciplinary team meetings and GPs told us how safeguarding alerts were placed on the records of vulnerable patients.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children with a deputy appointed to act in their absence. They had received appropriate training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority.

Systems were in place to identify potential areas of concern. For example, for clinical staff to identify children and young people with a high number of accident and emergency attendances and follow up of children who failed to attend appointments such as childhood immunisations.

A chaperone policy was in place, which was visible on the waiting room noticeboard and in consulting rooms. We saw records that demonstrated nursing staff had been trained to be chaperones, had received appropriate training and checks and understood the requirements.

Medicines management

During our inspection, 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. We saw that practice staff followed this policy.

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

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed and checks were made. The practice had a system in place to assess the quality of the dispensing process and records showed all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at Rother House Medical Centre or the branch surgery. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. A local delivery service was also operated.

Dispensary staff showed us the Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Stocks of controlled drugs were securely held, dispensed and disposed of in line with regulations.

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms

Good

Are services safe?

were handled in line with national guidance as these were tracked through the practice and kept securely at all times. The practice had also signed up to the electronic prescription service.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, changes to guidelines for the best management of polymyalgia rheumatica, an inflammatory medical condition.

Cleanliness and infection control

We noted that the premises to be visibly clean and tidy. Cleaning schedules were in place and cleaning records kept. The practice used a contract cleaner. Eight patients we spoke with or who had completed comment cards told us they always found the practice to be clean and had no concerns about cleanliness.

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 all staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the lead had carried out an infection control audit during March 2015 and annually in previous years. Any improvements identified for action were completed on time. No action points were needed from this latest infection control audit, however we noted that the previous audit had highlighted the need for some rooms within the practice to be tidied. This had been carried out and the concern had not arisen again.

An infection control policy, along with supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others. There were notices about hand hygiene techniques displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There was policy in place for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in August 2014 and a full legionella test was due to be undertaken during April 2015.

Arrangements were in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Equipment

Practice staff told us they had the necessary equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, September 2014. A testing schedule was in place and we saw records of calibration for equipment such as scales.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty every day. There was a staff rota in place during the week and always a member of clinical staff on duty. We were shown how staff rotas were prepared for four weeks in advance. Because some administrative staff were part time, they were able to work additional hours to provide staff cover if a staff member was unexpectedly absent. The practice monitored their workforce and reviewed staffing requirements to ensure sufficient staff were available to meet the needs of the population they served. We looked at the guidance in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, for the management of staff sickness, and planned absences.

There was a business continuity plan devised by the practice which advised what to do should there be a shortage of GPs and practice staff due to sickness for example. This included arrangements for using locum GPs, although we saw the need had never occurred. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

An up-to-date, comprehensive recruitment policy was used. It detailed all the pre-employment checks to be

Good

Are services safe?

carried out on a successful applicant before they could start work at the practice. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. If DBS checks were not required, for example, for administrative staff who did not work on their own with patients, a risk assessment had been carried out to confirm this. We looked at a sample of recruitment files for GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been correctly followed and all required checks completed.

The practice was also a training practice for doctors and regularly hosted trainee GPs from university. We saw how they were given appropriate training and supervision with the practice.

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 regular checks of the building, consulting rooms, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role. Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to manage emergencies. Records showed that staff had received regular training in basic life support. Emergency equipment at the practice included oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff we spoke with knew the location of the emergency equipment and we saw records which confirmed that it was regularly checked. Emergency medicines were available in a secure storage area and staff knew the location. These included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). 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.

There was a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. Copies of this were kept at the homes of GPs and the practice manager. Risks identified included power failure, adverse weather including flooding and access to the building. The practice carried out a fire risk assessment in November 2014 and all staff received regular fire safety training. If the practice building was unavailable, we saw arrangements were in place for the use of the branch surgery, if Rother House Medical Centre could not be used and vice versa if the branch surgery was out of action. An emergency control room would be set up in the practice manager's home.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

During our inspection, we saw that patients' needs were assessed and care and treatment was planned and delivered according to their individual needs and preferences. Patients we spoke with and those who completed comment cards were happy with the care they received and any follow-up needed once they obtained an appointment. Patients told us GPs and practice staff provided high quality care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), the name for a collection of lung diseases including chronic bronchitis and emphysema. Within the last 12 months, the practice had reviewed 69.5% of patients with asthma and reviewed the 82.6% of asthma patients' medication. Reviews had been carried out on 80% of patients with COPD and 91.6% of COPD patients' medication. A total of 89.19% of patients with heart failure had also been reviewed. This demonstrated patients with long term conditions were seen on a regular basis. Systems for diagnosing patients with cancer were also in place and between March 2014 and February 2015; the practice referred 495 patients with suspected cancer. All received secondary healthcare appointments within the two week target for suspected cancer.

Patients who required palliative care (palliative care is an holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. All had care plans in place and 87.7% of these patients had been reviewed within the last 12 months. Details of all patients who received palliative care were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

We saw how staff used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified (for example with the use of a particular painkiller that had been reclassified as a controlled drug in 2014) and staff were trained appropriately. The practice was part of a GP 'buddy group' for long term medical conditions which shared best practice.

Management, monitoring and improving outcomes for people

There was a system in place at the practice for completing clinical audit cycles. Examples of completed clinical audits included the use of non-steroidal anti-inflammatory drugs (NSAIDs), for example ibuprofen and naproxen. This saw a reduction of their usage by 14%.

Dates had been set to repeat audits to continue to determine their effectiveness. We found other monitoring the practice had carried out included patients with chronic conditions, for example diabetes. Some of this monitoring, including the NSAID clinical audit, was carried out as part of the Quality and Outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually. The practice's performance was average or above average in some areas for the South Warwickshire Clinical Commissioning Group (CCG) for QOF.

We saw how the practice was able to identify and take appropriate action on areas of concern. For example, when patients with long term medical conditions failed to turn up for review appointment, they were contacted by the practice to encourage them to re-book and the importance of attending their appointment was politely discussed.

When Tramadol, a painkiller, was re-classified as a controlled drug in June 2014, the practice had placed restrictions on its issue to ensure it was only prescribed for short term and intermittent use and was not prescribed to patients who received other strong pain killers. At the time of the audit, the practice had 86 patients who received tramadol on a repeat prescription, just over 1% of the total patient list. Following the initial audit, six patients were able to have tramadol withdrawn. When the audit was repeated in September 2014, 225 patients had tramadol prescribed, compared with 240 in the preceding three months. A further review was carried out in February 2015. This confirmed the practice had been able to reduce its prescribing of the medication and issue more appropriate alternatives with potentially fewer risks for the patients concerned.

Good

Are services effective?

(for example, treatment is effective)

We also saw evidence that the practice attended training events hosted by other local practices to identify and discuss best practice, for example, best practice for over 75s care as part of the CCG's Over 75s project.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support and safeguarding. GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff had annual appraisals that identified learning needs from which action plans were documented. Staff we spoke with confirmed this and told us the practice provided training and funding for relevant courses. As the practice was a training practice, the trainee doctor based at the practice had access to a senior GP for support when needed.

Nursing staff including Healthcare Assistants had clearly defined duties which were outlined in their job description. They were able to demonstrate that they were trained to fulfil these duties. For example, we saw certificates that demonstrated they were able to administer vaccines.

Working with colleagues and other services

It was clear the practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy which outlined the responsibilities for staff to pass on, read and act on any issues that arose 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.

Practice meetings were held weekly. During these meetings any concerns were discussed, for example, the needs of complex patients, those with end of life care needs or children on the at risk register. Every two months, a palliative care meeting was held. These meetings included the lead GP for palliative care, district nurses, the community matron and staff from the local Myton Hospice. Care needs were discussed and decisions about care planning were documented.

GP partners met every two weeks outside practice opening times. We saw evidence that clinical updates, difficult cases, significant events, emergency admissions to hospital and business needs were discussed and actions identified.

We saw records that confirmed the practice worked closely with the community midwife service and a weekly midwives clinic was held at the practice. There was also close working with the community mental health team and community drug teams. Clinics were held for blood testing, hypertension (high blood pressure), diabetes and cholesterol amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. As the majority of patients spoke English as their first language, all were in English, but management told us information could be provided in other languages if needed. Relevant information was also displayed on a screen within the patient waiting room.

Information sharing

Electronic systems were used by the practice to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its 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). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency (A&E) department.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We were shown processes to seek, record and review consent decisions. There were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients.

We saw the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options. We saw details of an occasion when a child aged under 16 saw a GP about a medical concern. The child was documented as being Gillick competent and this was recorded in the patient records.

Staff had an understanding of the Mental Capacity Act 2005 and demonstrated their knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

The practice had access to interpretation services if needed. This was only used occasionally for the local Polish community. Most such patients who needed an interpreter brought a family member with them to their appointment.

Health Promotion & Prevention

All new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. A total of 331 NHS health checks had been completed in the last 12 months, out of 445 that had been offered to patients, a take-up rate of 74.3%. The practice's performance for cervical smear uptake was above average compared to others in the Clinical Commissioning Group (CCG) area. A total of 644 patients had received cervical screening within the last 12 months, 5% of the total patient list. This was slightly above average for the CCG. Bowel cancer screening was also above average for the CCG at 8%. A total of 1057 patients were screened.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, smoking cessation support. Within the last 12 months, the practice had offered advice to 1303 patients, 9.8% of the total patient list. A total of 42 patients had not continued with the programme, 3.2% of those who started.

The practice hosted a weekly drop-in session by the Citizen's Advice Bureau. Patients were referred to this for a range of advice and services. This included referrals for assistance from Stratford Food Bank.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with and patient comment cards we received were complimentary about the care given by the practice and any follow-up needed once patients had obtained an appointment. Patients felt they were always treated with respect and dignity by all members of staff. Patients commented on how professional, friendly and helpful GPs and staff were. Some patients also mentioned how they felt GPs and practice nurses gave them the time they needed.

During our inspection we noted how staff and patients interacted with each other, in person at reception and over the telephone. Staff were polite, respectful and understanding towards patients. Staff we spoke with told us that patient care was central to everything the practice did.

During the 2014 national patient survey, 134 patients completed a patient survey issued by the practice. Of those patients who responded 96.3% said they were happy with the clinical care they had received from their GP. This was above the national average measured by NHS England. The sample represented 1% of the patient list. It was planned to repeat this survey later in 2015.

We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

As part of our inspection, we looked at patient choice and involvement. GPs told us how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. We were told by clinical staff that any changes needed to a patients' treatment or medication was discussed with them beforehand. This was confirmed by patients we spoke with. GPs told us how they treated patients with respect and ensured they were kept fully informed during consultations and subsequent investigations. This was confirmed by patients we spoke with. They told us decisions were explained clearly and options were discussed when they were available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

Patients told us that their GPs and nursing staff listened to them and gave us examples of advice, care and treatment they had received. Some patients we spoke with had long term conditions and they told us they were reviewed at least every year and sometimes more often.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provided for carers and links to refer patients to appropriate organisations. This included the NHS counselling service for professional support. Information was available in the waiting room about organisations specialising in providing bereavement support and patients were signposted to them when needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. It was clear the needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. For example, the practice had care plans in place for the most vulnerable elderly patients, a total of 1.85% of the patient list. This enabled the practice to be more responsive to their health needs and anticipate changes in their health and also to reduce unplanned hospital admissions.

The practice enabled homeless people and travellers to register as patients to enable them to access NHS services. There was a small traveller community based locally.

Services were planned to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. GPs provided examples of how the practice responded to the needs of the local community. As the practice is located in an area with a higher than average rate of employment, GP and practice nurse appointments were available until 6.30pm on three evenings per week and on alternate Saturday mornings. They were well attended. Of the 134 patients surveyed in 2014 national patient survey, 122 (91%) were happy with the practice opening times. This was above the national average. Review meetings were held with the South Warwickshire Clinical Commissioning Group (CCG) and a GP attended these. One GP partner was also a member of the CCG board and a practice nurse was associate medical director of Community Services at South Warwickshire Foundation Trust (SWFT).

The practice had an established Patient Participation Group (PPG). This was a group of patients registered with a practice who work with the practice to improve services and the quality of care. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with discussions to improve patient care, analyse and discuss action following the patient survey and promote on-line services.

Tackling inequity and promoting equality

Almost all who used Rother House Medical Centre spoke English as their first language. If other languages were needed, the practice used a translation service and could obtain literature in other languages on request.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible.

Access to the service

The practice opened from 8.30am to 5.30pm. This was extended to 8pm on two days every week. Practice nurse appointments were also available until 6.30pm on three evenings per week. The practice also held a surgery from 8.30 to 11.30am on alternate Saturday mornings. In addition, a telephone triage system was operated for patients who could not be immediately offered same day appointments. When the GP called the patient back, if they decided the patient needed to be seen the same day they would be called into the practice. Telephone consultations were also available.

Outside of these times and during the weekend, an out of hours service was provided by Care UK Warwickshire and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside the practice's opening hours.

Appointments could be booked for the same day, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice. Medicines could be delivered by the dispensary to patients who lived over one mile away from the practice.

In 2014, 134 patients completed the national patient survey. This represented 1% of the patient list. Of the patients surveyed, 80.6% (108) were happy with the appointment system, average for the CCG.

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were usually able to get an appointment on the same day they phoned if this was needed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with

Good

Are services responsive to people's needs?

(for example, to feedback?)

recognised guidance and contractual obligations for GPs in England. It identified how complaints would be dealt with and the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

The practice manager was the designated responsible person who handled all complaints in the practice. The practice had only received one formal complaint within the last twelve months. We examined this complaint. It concerned a breakdown in communication between a patient and a member of staff. The complaint was investigated and responded to in a way which satisfied the patient.

We looked back at older complaints and saw historically how patients' concerns were listened to and acted upon. We found complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given an explanation and when appropriate, an apology. There was information about how to complain displayed in the waiting area. All of the patients we spoke with said they had never had to raise a formal complaint.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available. The practice had a policy to give every patient who wished to speak with the practice manager the opportunity to do so.

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

Rother House Medical Centre aimed to ensure high quality, safe and effective services in a safe, clean and healthy environment. This was displayed on the practice website and in literature produced by the practice.

GPs we spoke with demonstrated how the practice kept up to date with research and governance recommendations and communicated these accordingly. We also saw how the GP partners kept the practice vision under review and communicated it to all staff through staff meetings and internal communications. We spoke with three GPs and six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

In discussion with staff, it was clear the team at the practice shared a desire to provide patients with a safe and caring service where patient needs were put first. GPs and staff told us the working environment was busy, but friendly and supportive.

GP partners held regular partners' meetings every two weeks outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. We were shown how the practice regularly reviewed these objectives at staff meetings.

The practice had developed a five year plan. This anticipated the needs of the local population, an increase in patient numbers and patient expectation and the context of the practice within the political landscape.

Governance Arrangements

All GP partners all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities.

There was a culture of teamwork, support and open communication within the practice. There was a weekly practice meeting which included clinical staff. This included discussions about any significant event analyses (SEAs) that had been done. This ensured learning was discussed and shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues. Succession planning was in place for GP partners. Regular practice meetings were also held with both clinical and non-clinical staff.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually. The practice's performance was average or above average in some areas for the South Warwickshire Clinical Commissioning Group (CCG) for QOF. We saw examples of completed clinical audit cycles, such as steroid prescribing. This showed the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners who provided consistent and stable leadership. They were supported by a practice manager and assistant practice manager who were described by clinical and other staff as central to the smooth running of the practice. Staff told us management and GPs were very approachable and they would have no hesitation if they had to raise any concerns with them.

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

There was an established Patient Participation Group (PPG) in place at the practice. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care.

This ensured patient views were included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as promoting on line patient services.

Staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients

Are services well-led?

Good

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

who used the service. We saw that there were systems in place for the practice to analyse the results of the survey so that any issues identified were addressed and discussed with all staff members

We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

The practice was focussed on quality, improvement and learning. There was a staff development programme for all staff within the practice, whatever their role. As an example of staff learning and development, the practice employed apprentices who were fully trained for a range of administrative duties. One apprentice we spoke with had just been offered a permanent role within the practice and said her training had been excellent.

The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such as first aid and advances in diabetes diagnosis had been covered.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.