Forest Glades 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 Forest Glades Medical Centre on 10 December 2014. The inspection team was led by a CQC inspector and included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience who had personal experience of using primary medical services.

We found Forest Glades Medical Centre provided a good service to patients in the key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had systems for monitoring and maintaining the safety of the practice 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 a well-established and well trained team of staff who had expertise and experience in a wide range of health conditions.

We saw several areas of outstanding practice including:

- The practice had obtained funding to provide additional health checks on its highest risk patients aged over 75. This comprised a total of 120 patients who had not visited the practice for over 18 months and may therefore have had difficulty accessing healthcare services.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Clinical Excellence and used it routinely. Patients' 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 planned. The practice could identify appraisals and the 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared 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. Every staff member had received an induction, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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 vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its flu vaccination programme. The practice nurse planned to provide these for patients in their own homes if their health prevented them from attending the clinics at the surgery. The practice worked with two local care homes to provide a responsive service to the patients who lived there.

The practice had obtained funding to provide additional health checks on its highest risk patients aged over 75. This comprised of a total of 120 patients who had not visited the practice for over 18 months and may therefore have difficultly accessing healthcare services. Patients received a home visit to review medication and have checks on their weight, blood pressure and pulse. nosed renal (kidney) failure.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions, for example asthma and diabetes.All of 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. This included working with a community matron who provided support to patients with long term medical conditions.

Families, children and young people

Good

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

Summary of findings

examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. The practice provided a family planning service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of 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 and those with a learning disability. The practice had carried out annual health checks for patients with a learning disability and offered them longer appointments if needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. This included the local Learning Disability Enhanced Service. The practice had informed 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.

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 patients 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 described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information. Care plans were in place for all patients with dementia. We were told copies of these plans were also held in patients' homes.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 24 CQC comment cards patients had filled in and by speaking in person with ten patients. Most 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 NHS England GP patient survey showed that the practice scored highly nationally for satisfaction with the practice.

Patients were positive about their experience of the services provided at Forest Glades Medical Centre. They told us they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful. Patients also told us doctors and practice nurses gave them the time they needed. One patient told us how supportive the practice had been following a bereavement. Patients said they were able to obtain appointments when needed, could get through to the practice on the telephone and would always be seen in an emergency.

Outstanding practice

- The practice had obtained funding to provide additional health checks on its highest risk patients aged over 75. This comprised a total of 120 patients who had not visited the practice for over 18 months and may therefore have difficultly accessing healthcare services. Patients received a home visit to review medication and have checks on their weight, blood pressure and pulse.

Forest Glades 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 two specialist advisors (one a GP, the other a practice manager) and an Expert by Experience. An Expert by Experience is someone who has experience of using a particular service, or of caring for someone who has.

Background to Forest Glades Medical Centre

Forest Glades Medical Centre is situated close to Kidderminster town centre. The practice has been in existence for over 40 years. It is located within Kidderminster Medical Centre and shares the premises with another GP practice and a range of NHS healthcare services. In 18 months' time, the GP practices at the medical centre will merge to form one practice and move to a new location which is shortly to be built. Plans have been finalised for this and were displayed in the patient waiting area.

The practice is in an area with some pockets of social and economic deprivation. The practice has a higher proportion of patients with long term medical conditions and who smoke. The practice provides care to people in a local dementia care home. it also continues to provide care for its own patients who are admitted to the Wyre Forest Community Unit.

Within the building there are a range of NHS services including blood testing, chiropody, physiotherapy and anti-coagulant testing. Bereavement and mental health counselling sessions are held there. Community midwife services are located at a nearby children's centre.

The practice has five GP partners, four male and one female. The practice has four practice nurses and a healthcare assistant. The clinical team are supported by a practice manager, and a team of administrative and reception staff. When the practice merger takes place, all staff, including GP partners, will be combined to form one team. Staff have been fully consulted about this.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

This was the first time the CQC had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that the practice was achieving results that were above average with other practices within the area.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services 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.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

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.

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 hold about the practice and asked other organisations to share what they knew. These organisations included Wyre Forest Clinical Commissioning Group (CCG), NHS England area team and Worcestershire Healthwatch. We carried out an announced visit on 10 December 2014. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with ten patients who used the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- 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

The practice used a range of information 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we reviewed a complaint where a patient had been refused a repeat prescription and saw how this had been dealt with in a timely way.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so showed evidence of a safe track record over the long term. We saw a detailed list of safety alerts the practice had monitored which went back over several years.

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 and we reviewed these for the last two years. Significant events were a regular item on the practice meeting agenda and regular agenda items reviewed actions from past significant events and complaints. These meetings were held every month. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, the results of a patient's Electrocardiogram (ECG) had not been reviewed. This is a process that uses equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. This was quickly identified and actioned. Additional checks were put in place to ensure it would not happen again.

Staff used incident forms and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked three incidents from the last 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. oFr example, some patients had been discharged from hospital and the practice had not received information about treatment or medication they had received. The practice raised this with the hospital concerned and obtained information required in a timely manner to ensure the correct treatment was carried out by the practice.

National patient safety alerts were disseminated during practice meetings to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example, recalls of batches of ibuprofen and warfarin (blood thinning) medication.

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 highest level of training to enable them to fulfil this role. All other staff had been trained to a level which enabled them to recognise signs of potential abuse. We saw evidence refresher training had been carried out within the last 12 months. All staff we spoke to were aware who the safeguarding leads were and who to speak to in the practice if they had a safeguarding concern. Monthly multi-disciplinary team meetings were held to discuss safeguarding concerns.

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 patients with a learning disability, for which the practice held a register of patients.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All clinical staff had been trained to be a chaperone

Good

Are services safe?

We were shown systems in place for the identification and follow up of children, young people and families living in disadvantaged circumstances; for the follow up of children who persistently failed to attend appointments, such as for childhood immunisations; and for reviewing repeat medications for patients with multiple medications.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw there were 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Cleaners were employed by Worcestershire Health and Care Trust, who owned the building. 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 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits, the latest in September 2014 and that any improvements identified for action were completed on time. The practice also carried out regular infection control risk assessments.

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 were also policies for needle stick injury and bodily fluid spills amongst others.

The owners of the building had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be fatal). This had been carried out in January 2014.

We saw records that confirmed the practice was carrying out regular checks in line with these policies to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had 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, December 2013. This was confirmed by the records held by the practice. We saw a schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Some administrative staff had not been given DBS checks, but a risk assessment had been carried out by the practice to determine a low level of risk from these staff members, for example, they did not spend time with patients alone. The practice had a

Good

Are services safe?

recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A recruitment checklist was used by management to ensure nothing was missed during the recruitment process.

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.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We were shown how staff rotas were prepared in advance. Staffing levels were then monitored weekly and adjustments made if needed due to demand.

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 annual and monthly checks of the building (undertaken by the owner), the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We were shown evidence of the last fire safety check. This was carried out monthly.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at the weekly GPs meeting and within the monthly team meetings. For example, a recall of a Hepatitis B vaccination had recently been discussed.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly or had been admitted to hospital in an emergency.

Arrangements to deal with emergencies and major incidents

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

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 and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, information technology failure, flood, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment in September 2014 in conjunction with the owner of the building that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We were shown the last fire safety report which had not raised any concerns.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for a possible outbreak of flu amongst the staff and the mitigating actions that had been put in place to manage this.

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. We saw minutes of practice meetings where new guidelines were disseminated, for example, regarding the prescribing of aspirin with patients at risk of a stroke. We saw evidence that the implications for the practice's performance and patients were discussed and required actions agreed, for example, when a batch of Hepatitis B vaccination had been recalled. 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.

The GPs told us they led in specialist clinical areas such as muscular skeletal conditions, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The GP partners were responsible for the majority of lead roles and deputies were identified for lead role cover if they were absent from the practice. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of patients who received medication to thin their blood (for example, warfarin). We were shown records to confirm this.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. These were regularly audited.

National data showed that the practice was above average or in line with referral rates to secondary and other community care services for all conditions. The rates for patients who attended accident and emergency were below average with other practices within the Clinical Commissioning Group (CCG). All GPs we spoke with used national standards for the referral of patients identified following cervical screening.

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

Management, monitoring and improving outcomes for people

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 showed us twelve clinical audits that had been undertaken in the last year. All were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, for example in earlier identification and treatment for patients with smoking related conditions.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding end of life care. Following the audit, the GPs carried out reviews of all patients aged over 90 and included care home management when patients lived in care homes. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Clinical staff held a meeting every month. The staff we spoke with discussed how, as a group, they

Good

Are services effective?

(for example, treatment is effective)

reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

The practice 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.

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

Effective staffing

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

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 that outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. We saw evidence of how the practice had to obtain discharge summaries from a hospital after the hospital experienced delays sending them to the practice.

We saw that the policy for actioning hospital communications was effective. The practice undertook a monthly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

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

Information sharing

The practice used several electronic systems 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 all 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).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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 them. All of the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Staff at the practice told us copies of the care plans for patients with dementia were also kept in their homes. This included the nursing homes the practice was responsible for and patients' private homes. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice offered well person checks, blood pressure checks, smoking cessation, dietary and exercise advice.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoked.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check. We saw how the practice sent text messages to friends or family of some patients with a learning disability just before their appointment time to remind them. We saw how appropriate consent had been obtained for this.

Mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was comparable to other practices within the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The practice nurse was responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

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 a survey of 125 patients (1.75% of the patient list) undertaken by the practice. The evidence from 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 survey undertaken by the practice in February 2014 showed 91% of patients felt their GP gave them enough time and 95% of patients felt their GP listened to them. The results were above average for all practices within the Clinical Commissioning Group (CCG).

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 24 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One patient told us how supportive the practice has been after a bereavement. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice, had no difficulty getting appointments or getting through on the telephone and said their dignity and privacy was respected.

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

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 they would investigate these and any learning identified would be shared with staff. There were no occasions where concerns had been raised.

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. The results from the practice's own satisfaction survey showed that 90.2% of patients said they were sufficiently involved in making decisions about their care.

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 consistently positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice had very few patients who needed this service.

Patient/carer support to cope emotionally with care and treatment

Comments made by patients we spoke with showed patients were positive about the bereavement support provided by the practice and rated it well in this area. Patients told us staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the 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. The practice identified carers on its patient list and had offered them appropriate signposting to services for additional support. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. This included the plan to merge with the neighbouring GP practice. This initially arose out of concerns for the aging building and lack of space inside.

The practice manager told us how the practice planned to implement suggestions for improvements and make changes to the way it delivered services in response to feedback from patients and staff, for example with the layout of the planned new building.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, one of the care homes the practice provided care for had a high number of patients with dementia. Care had been taken to monitor changes to their health needs and ensure these needs were met. The practice reviewed their care and held joint meetings with care home management on a regular basis.

The practice had access to online and telephone translation services for patients whose first language was not English. The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed equality and diversity training. This had recently been carried out again.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice kept a register of people living in vulnerable circumstances and the computerised system used in the practice alerted staff to vulnerability in individual patient records.

Access to the service

Appointments were available from 9am to 6pm on weekdays with a break from 1pm to 2pm. Appointments and telephone consultations outside of these hours could be arranged for patients who worked. We saw that additional appointments for emergencies could be added to the end of standard surgery sessions.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the surgery itself and in the practice information leaflet. The practice did not have a website, although one was being developed to launch when the practice merges with the neighbouring GP practice.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to or they could wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available in the waiting room and in the patient information leaflet to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint, but had never needed to use it.

We looked at four formal complaints received in the last 12 months and found these had been handled and resolved promptly in line with the practice's complaints policy. The practice reviewed complaints on an on-going basis to detect themes or trends. We checked the reviews and saw that no consistent themes had been identified; however

Good

Are services responsive to people's needs?

(for example, to feedback?)

lessons learnt from individual complaints had been acted upon. For example, we saw a complaint about misunderstanding with a GP after a discharge from hospital. There were no complaints about safety related issues.

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 improve the health of its patients, deliver high quality care and promote good outcomes for patients. This was clearly stated within information produced by the practice.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the staff meeting held in September 2014 and saw that staff had discussed the vision and values.

In 18 months' time, the practice will merge with the neighbouring GP practice to form one practice and move to a new location which is shortly to be built. We were shown the plans and consultation documents for this. Additionally, the plans were displayed in the patient waiting area. Staff and patients have been fully consulted about the changes and how they will be affected.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and saw records to confirm they had been discussed in staff meetings.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the lead GP was the lead for safeguarding.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits for end of life care and warfarin (a blood thinning medication) prescribing.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as missed vaccinations. We saw that the risk log was regularly discussed at team meetings and updated in a timely way.

The practice held monthly governance meetings. We looked at minutes from two of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held approximately monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction and sickness management, which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the latest annual patient survey which had been carried out in February 2014 and 98.3% of patients said they found the practice staff helpful or very helpful.

The practice did not have a Patient Participation Group (PPG) in place. Staff told us the practice had tried to start a PPG on a number of occasions, but these had been unsuccessful. The practice Forest Glades Medical Centre is planned to merge with has an established PPG. It was intended to use their expertise to broaden this to include the Forest Glades Medical Centre patients after the practice merger took place.

The practice had gathered feedback from staff through its staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. One staff member had suggested an improved filing system for prescriptions waiting to be issued and this was about to be implemented at the time of our visit.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff and electronically on any computer within the practice. Staff were aware of this and mentioned it when asked.

Management lead through learning and improvement

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

We saw that staff had protected learning time at regular intervals. This covered topics such as data protection and equality and diversity.

The practice had completed reviews of significant events, complaints and other incidents and shared the results with staff through meetings and protected learning time to ensure the practice improved outcomes for patients.