River Wey Medical Practice

Quality Report

The Farnham Centre for Health
Hale Road
Farnham
Surrey
GU9 9QS
Tel: 01252 737387
Website: www.farnhamgps.com

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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

River Wey Medical Practice was inspected on 2 October 2014. The inspection was a comprehensive inspection.

Overall the practice provided a good service for patients.

Our key findings were as follows:

- Patients were able to access same day appointments in case of an emergency.
- Patients were treated with dignity and respect and involved in their treatment.
- Each patient had a name GP to promote individualised care.
- Specific appointments were available which could only be booked by a GP for patients who had received hospital or outpatient treatment
- Another example was the use of a British Sign Language (BSL) interpreter, a receptionist explained they were aware of that a patient had reduced hearing and had booked a BSL signer to be present at their appointment.
- A copy of the practice information leaflet in CD format was also available for patients who have impaired vision.

We saw areas of outstanding practice including:

- Joint consultations with GPs and psychiatrists to assess patients' needs.

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

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included an assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned forc. There were appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team and clinical commissioning group to secure service improvements where these were identified. Patients reported good access to the practice and a named GP, continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear

Summary of findings

leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people
The practice is rated as good for the care of older people. The practice was responsive to the needs of older people, including rapid access appointments for those with enhanced needs and home visits and end of life care. Appointment reminders were recorded on a card and followed up in writing.

Good

People with long term conditions
The practice is rated as good for the population group of people with long term conditions. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good

Families, children and young people
The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There were good examples of joint working with midwives, health visitors and school nurses.

Pre bookable appointments were available for patients who worked and post natal checks at eight weeks were organised along with baby health checks. Childhood immunisations were offered at intervals outlined in national guidance.

Good

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

Good

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients who were vulnerable, such as those with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies including outside opening times.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

Staff had received training on how to care for people with mental health needs and dementia. Patients were provided with information on local memory cafes and drop in centres for patients experiencing mental health problems.

Summary of findings

What people who use the service say

We received a total of 35 comment cards. All of the patients who completed a card considered that the practice was very good or excellent. Three patients commented that sometimes appointments ran late and two people said they had difficulty in arranging an appointment over the telephone. However, one patient said that there had been a big improvement in obtaining an appointment since the telephone queuing system had been introduced. All six patients we spoke with said they were always seen in an emergency on the same day when needed. Other comments received included patients being listened to and their questions being answered clearly and concisely by GPs and nurses. All respondents said that they were treated with respect and their privacy and dignity was maintained.

During our inspection we spoke with six patients who all considered that they received appropriate care and treatment. They told us they were able to get emergency appointments when needed and were referred for further treatment at the local hospitals.

The patient survey information 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 the majority of patients said they were sufficiently involved in making decisions about their care. Data from the national patient survey showed the practice was rated as good or very good by 90% patients.

Areas for improvement

Outstanding practice

The practice offered joint consultations with a GP and psychiatrist for patients experiencing poor mental health. The practice also facilitated a 'hot desk' system where patients could access their community psychiatric nurse.

River Wey Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a second CQC inspector and a practice manager.

Background to River Wey Medical Practice

River Wey Medical Practice is situated in an urban area of Farnham at: The Farnham Centre for Health, Hale Road, Farnham, Surrey GU9 9QS.

The practice has four GP partners; two male and two female, one salaried GP and a practice nurse, who are supported by a team of receptionists, administrators, a practice manager and a deputy practice manager.

The practice has approximately 6700 patients registered with it and patients are from all population groups, with a higher proportion than the national average of patients in the working age group.

Out of hours services are through another provider.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Healthwatch, NHS England and clinical commissioning group, to share what they knew. We carried out an announced visit on 2 October 2014. During our visit we spoke with a range of staff which included GPs, the practice manager, nursing and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- 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)

River Wey Medical Practice percentage of their patients in the age groups were in line with the average for England. Apart from the percentage of patients between the ages of 45 to 54 and 60 to 69 which is higher than the average for England. The practice population ratio is slightly higher male to female.

Good

Are services safe?

Our findings

Safe Track Record

All staff we spoke with were aware of the need to report significant events or near misses and said that they would report to their line manager in the first instance. Safety alerts received by the practice from organisations such as, Medicines and Health Regulatory Authority (MHRA), were disseminated to all staff and acted upon if needed. This information was stored within the practice's database.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events. We reviewed the significant event log and analysis. We found that these were discussed at practice meetings and action needed to minimised reoccurrence were put into place when needed. There was evidence that learning had occurred and information was disseminated to relevant staff.

Reliable safety systems and processes including safeguarding

All staff in the practice had undertaken e-learning on safeguarding adults and children at the appropriate level. For example, GPs had undertaken Level 3 training. Staff we spoke with confirmed this and also we found that the practice's training and development plan showed that training had occurred. The practice manager informed us that two members of staff from the practice, a GP and the senior receptionist were due to attend a one day training course arranged by the local authority on safeguarding adults. Records we looked at confirmed this.

Staff were able to explain what actions they would take if they suspected an adult or child was at risk of abuse and who they would report this too. When required markers could be placed on the computer data base to ensure all health professionals were aware of who needed to be involved in the care of a vulnerable patient.

The practice had a chaperone policy and staff told us they had been trained in being a chaperone. (A chaperone is a person who accompanies another person during treatment or examination). We heard a receptionist talking with a patient on the telephone who needed an examination. The receptionist was discreet about the nature of the examination and said that a chaperone could be arranged if needed. Training records showed that all staff had undertaken chaperone training.

Medicines Management

We checked the emergency medicines box and equipment available for use in an emergency, such as the Automatic External Defibrillator (AED). We checked medicines stored in the treatment rooms and fridge and found that they were stored appropriately. The practice kept records of daily checks of fridge temperatures and we found these were within safe limits. There was a clear policy for maintenance of the cold chain and action to take in the event of a potential failure. Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and in date and all staff knew their location.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how staff who generate prescriptions were trained, how changes to patients' repeat medicines were managed and the system for reviewing patient's repeat medicines to ensure the medication was still safe and necessary.

Cleanliness & Infection Control

The practice had a designated infection control lead who carried out an annual audit of infection control processes at the practice. Any improvements identified for action had been completed. Relevant staff had received training on infection control and annual updates. On the day prior to our inspection staff had been required use a spillage kit to clean an area of the carpet in one of the treatment rooms. This had caused the carpet to become discoloured; the practice manager said they were in discussion with the buildings management company to arrange replacement flooring.

We saw the premises were visibly clean and tidy. High dusting had been carried out and a daily check list had been completed on areas cleaned. We spoke with the infection control lead about processes used to minimise the risk of infection. They were able to explain the importance of damp dusting equipment and couches between patient appointments. They said that if a patient had a complex dressing they would wash their hands and change their gloves throughout the process to protect the patient from harm.

Disposable instruments were used for minor surgery procedures and disposed of in clinical waste bins. The practice had a clinical waste contract in place to ensure it was disposed of safely. Records were confirmed showed that this process had been followed. The infection control

Good

Are services safe?

lead said that they used an ultra-violet light machine to identify areas on hands which have not been effectively cleaned. They said that at least once a year all staff had their hand washing technique checked using this machine and all new starters were assessed.

We noted that the infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures and to comply with relevant legislation. The policies were available on the practice's computer systems.

Records obtained from the buildings management company showed that Legionella checks had been carried out and there were no concerns. (Legionella is a bacterium found in water storage tanks which can pose a risk to patients' health).

Equipment

The practice had suitable arrangements in place to ensure equipment used at the practice was safe to use. We looked at the Portable Appliance Testing (PAT) and equipment calibration records and found that checks were made every two years on portable appliances. Annual checks had been carried out on other equipment in line with manufacturers recommended guidance. Other checks which had been carried out to ensure that equipment was safe to use included weekly checks on medicines expiry dates and the defibrillator for emergency use. The records showed that equipment was maintained and safe to use.

Staffing & Recruitment

We looked at recruitment records of two members of staff who had been recruited in the past 12 months. We found both members of staff had all relevant information in their files, which included evidence of past employment, checks on professional registration, if needed and proof of identity. Appropriate checks had been carried out prior to the member of staff commencing employment including a criminal records check via the Disclosure and Barring Service (DBS) and references from previous employers. Staff needing to be a chaperone had also had DBS checks.

Monitoring Safety & Responding to Risk

We saw records that all staff had received training in Basic Life Support within the last two years. A GP and the practice nurse told us that the previous day there had been an emergency incident where a patient had collapsed in the practice. Immediate first aid was given and the emergency medicines and Automated External Defibrillator were ready to be used if needed.

The practice had systems in place for managing staff absence, annual leave and staff members leaving for other employment. The practice manager told us that they were leaving at the end of October 2014 and was in the process of completing a handover period of three months with their successor. Patients and staff had been informed and we saw that arrangements were in place to ensure seamless management cover.

Staff said that they were able to cover each other in the event of sickness or annual leave and had received appropriate training to enable them to do this.

A health and safety risk assessment had been carried out in September 2014 and any issues identified were resolved. The buildings management company was responsible for checks of fire alarms. Records we looked at showed that fire alarm points were checked on rotation throughout the building on a weekly basis.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan in place in the event of an emergency or interruption to service provision. We found that hard copies were available for use by the nominated GP and practice manager. Telephone systems could be set up if needed externally to the practice, to ensure patients continued to receive a service. A box with relevant paperwork was available at the reception in case of an emergency. There were no formal buddy arrangements in place with the other two practices in the building; however the practice manager told us they would work collaboratively if needed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment Effective needs assessment

The practice used a software system which had templates based on best practice produced by organisations such as the National Institute for Clinical Excellence (NICE).

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from NICE and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurse that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, mental health and asthma and the practice nurse supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, the practice nurse said that they were able to discuss cases with a GP when needed.

National data showed the practice was in line with performance for antibiotic prescribing and provision of flu vaccines. Patients were able to access the 'book and choose' service to arrange hospital appointments or follow ups. We saw minutes from meetings where regular reviews of accident and emergency admissions were made to identify patients who may have attended instead of accessing the practice's services or other primary care services. Arrangements were made to contact these patients to provide information and advice if needed. Improvements to practise were shared with all clinical staff.

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

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included diabetes blood monitoring and oral nutrition supplements. (These are high calorie drinks which are prescribed when a patient is at risk of malnutrition). We found that the records should that the audit cycle was complete with actions taken and reviews occurring to monitor any improvements.

The practice were aware of national guidelines for best practice including NICE and the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for how well they care for their patients. The results are published annually.) There were processes in place to monitor the practice performance in relation to these. The practice achieved a percentage of 95% for QOF in the year 2012/13. The practice manager said they had signed off the results for QOF for 2013/14 and had established practice based codes to work on areas for improvement.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. For example we saw an audit regarding the prescribing of pain relief and nonsteroidal anti-inflammatory drugs. Following the audit the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon 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, noting that there was an expectation that all clinical staff should undertake at least one audit per year. Records we looked at confirmed this.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also

Good

Are services effective?

(for example, treatment is effective)

checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary.

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 mandatory courses such as annual basic life support.

We looked at training records and spoke with staff about training provided by the practice. We found that training had been provided in areas such as infection control, reception duties, equality and diversity and fire safety. All front line staff had received dementia awareness training to enable them to recognised signs of dementia and give appropriate assistance to patients. Training was accessed online and in face to face sessions, depending on the subject being taught. There were plans in place for refresher sessions when needed.

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had undertaken a diploma in diabetic care.

The practice nurse had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and the Out of Hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patents 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 decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice had an ultrasound suite which enabled patients to receive an ultrasound more quickly than if they had been referred to the local hospital. This service was also used by other practices in the area.

Appropriate arrangements were in place for dealing with blood and urine samples. These were collected three times a day from the practice and taken to the local hospital for analysis. One of the collection times was in the evening, so samples did not require storage in the practice overnight.

The practice manager gave examples where they had worked with other practices and led on projects such as in winter 2013/2014 the Farnham Urgent Visiting Service, which operated over the winter months and consisted of a GP being available to visit patients during normal hours to provide treatment.

Information Sharing

Information from Out of Hours providers was sent to the practice each morning and reviewed by GPs. If needed review appointments were made to monitor a patient's condition. The practice contacted the out of hours provider if they had concerns about a patient who might need to be seen.

The practice worked with the palliative care team and had regular meetings to discuss patients who were receiving end of life care. This information was collated in one record and shared with the Out of Hours provider and hospital or hospice when needed.

Good

Are services effective?

(for example, treatment is effective)

The practice was situated in a health centre and was able to access other health professionals, such as district nurses and health visitors. The practice manager told us about the links they had with the community matron who was responsible for care homes in the area. On the day of our inspection we saw the community matron visit the practice to discuss the care of a patient living at a care home who was registered with the practice.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. An example given was that of a young patients who had learning disabilities and was reluctant to have blood taken. The GP worked with the patient and their advocate to find a way of carrying out the required tests another way.

Patients with learning disabilities and those with dementia were supported to make decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. 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 & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 75 years or older.

The practice had several ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. Similar mechanisms of identifying at risk groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

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 & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 280 patients undertaken by the practice's patient participation group, which was targeted to obtain 40 completed questionnaires per GP and practice nurse employed by the practice. The evidence from all 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 national patient survey showed the practice was rated as good or very good by 90% patients.

Patients completed Care Quality Commission comment cards to provide us with feedback on the practice. We received a total of 35 comment cards. All of the patients who completed a card considered that the practice was very good or excellent. Other comments received included patients being listened to and their questions being answered clearly and concisely by GPs and nurses. All respondents said that they were treated with respect and their privacy and dignity was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Cleanable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. The practice also had a 'privacy booth' where patients could discuss private matters. Reception staff said this was often used by young patients or those with poor mental health. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. We also saw that reception staff asked patients who telephoned for a same day appointment were asked politely if the patient considered the situation to be urgent.

Patients whose circumstances may make them vulnerable were able to access the practice without fear or stigma. The practice had trained all reception staff on dementia awareness to enable them to deal empathetically with patients who may have this condition. Patients experiencing poor mental health could receive care by attending to see a GP and psychiatrist during one appointment.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both these results were marginally below average compared to the national average. However, 90% of patients described their overall experience of the practice as good or very good, which was above the national average. The results from the practice's own satisfaction survey showed that the majority of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice's website had a specific section for young patients to access, which included links to information on sexual health, mental and physical wellbeing and bullying.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. For example, 86% of respondents to the patients participant group survey said when it had been needed they were helped to access support services to help them manage their treatment and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations, such as bereavement counselling and carers groups.

Clinics were available for patients to access if they had long term conditions such as asthma, diabetes or chronic obstructive pulmonary disease. Patients receiving palliative care were reviewed with other members of the multi-disciplinary team and the practice's end of life care register was accessible to Out of Hours providers.

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.

Patients who had poor mental health were able to access a Community Psychiatric Nurse (CPN) 'hot desk' if needed and appointments with both a GP and psychiatrist were offered. The practice had an ultrasound suite which was used by patients registered at the practice and other patients within the clinical commissioning group. This enabled patients to have a scan without needing to travel to the local hospitals and results were available more quickly for GPs to review. Bookable appointments were available for five days a week for patients who commuted for work.

GPs told us that they were able to access the NHS system to review patients who had attended A & E and this data was 'real time'. This meant that if a patient had attended A & E, then once the practice opened a check could be made on who had attended the previous evening or night and information on their condition added to the patient record for follow up if needed.

Each patient had a named GP to ensure continuity of care. Specific appointments were available which could only be booked by a GP for patients who had received hospital or outpatient treatment. Home visits were available for patients who were unable to visit the practice.

When there were staff changes at the practice consideration had been given to informing patients and suitable handover periods being arranged between staff leaving and the new post holder taking over. For example, one GP was due to retire and arrangements had been made to allocate their workload and management responsibilities between other partner GPs in the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group. This included reviewing the telephone queuing system and promoting of the online appointment booking system.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs, to ensure their needs were being met.

The practice manager told us that if an older patient required additional assistance, for example to go to the outpatient department or pharmacy situated in the same building, then a member of staff would escort the patient there.

Tackle inequity and promote equality

Staff told us that translation services were available for patients who did not have English as a first language. These comprised of interpreters and a language line service which had been used in the past month. Another example given was the use of a British Sign Language (BSL) interpreter, a receptionist explained they were aware of that the patient had reduced hearing and had booked a BSL signer to be present at their appointment. A copy of the practice information leaflet in CD format was also available for patients who had impaired vision.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities. There were low level kerbs and automatic doors to the main entrance. The practice was situated on the ground floor of the building. We saw the waiting area had a selection of differing height chairs for patients to choose to sit on. There was a hearing loop installed for patients with reduced hearing. (A hearing loop allows patients who use hearing aids to set them to a specific channel which blocks out unwanted background noise).

Access to the service

Appointments were available from 8.20 am to 6.30 pm on weekdays. In addition there were extended opening hours each morning from 7.30am specifically for patients with work commitments. Times of last appointments varied dependent on which GP was available, these were clearly set out in the practice leaflet and on the website. Information on nurse only appointments showed that these were available on weekdays at 8.20am to 12.50pm, 1.10pm to 3pm and 2.10pm to 6.30pm. There were

Good

Are services responsive to people's needs?

(for example, to feedback?)

dedicated telephone appointments from 12pm to 3pm daily and a proportion of appointments were made available in the morning for emergency consultations. Patients could also see a midwife on Mondays between 1pm and 2pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements 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.

Patients were generally satisfied with the appointments system. Six patients told us that they could see a GP on the same day if they needed to and they could see another doctor if there was a wait to see the GP of their choice.

Three comment cards showed that sometimes appointments ran late and two patients said they had difficulty in arranging an appointment over the telephone. However, one patient said that there had been a big improvement in obtaining an appointment since the telephone queuing system had been introduced.

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.

Listening and learning from concerns and complaints

We saw that information was available to help patients understand the complaints system this included information on the website, within the practice leaflet and information on the digital display. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

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

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

We looked at eight complaints received in the last twelve months, each had been acknowledged within 24 hours and efforts were made to resolve the situation when possible within a few days. Records included that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required. We noted there were no common themes to complaints received.

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 and strategy for development and growth, such as working collaboratively with other practices in the area to maximise patient choice. This was cascaded to all staff who worked at the practice. Staff we spoke with confirmed they knew what the business plan was and were involved in shaping it.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at these policies and procedures which included data security management and confidentiality. Policies and procedures we looked at had been reviewed annually and were up to date. The practice had a named Caldicott guardian who was responsible for ensuring that information was held and managed securely.

The practice held weekly practice meetings. We looked at minutes for the previous year and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line or above with 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 manager said that they had collated the results of this year's QOF and had implemented local codes to address any areas which required improvement and will use this information when the QOF codes are known.

The practice had completed a number of clinical audits, for example diabetic monitoring, antibiotic prescribing and cervical smear testing. Learning from these audits had taken place when needed and reviewed.

Leadership, openness and transparency

The practice had a clear leadership structure in place. For example, the practice nurse was responsible for infection control and one of the GP partners was responsible for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least 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.

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

The practice had a small patient participation group (PPG) with four patients at the time of the inspection and they were actively seeking more members. We spoke with a member of the patient participation group about their work. They told us that the group met each quarter and six monthly with other GP practices in the area. They said that GPs attended their meetings and were approachable and receptive to ideas. The PPG had carried out an annual survey and produced an action plan in November 2012; this was reviewed again in March 2013. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at training records and saw that yearly appraisals took place which included a personal development plan. The practice nurse confirmed they had received an appraisal and were supported to learn and improve and had obtained qualifications in areas such as child health and diabetic care.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. For example one incident concerned lack of accurate recording of immunisations given to a child. This was investigated and action taken to prevent any reoccurrence.