Shepherds Spring Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 6 November 2014. The inspection was a comprehensive inspection.

The overall rating for this service is good. We found the practice to be good in the effective, caring and well-led domains and good in the safe and responsive domains. We found the practice worked effectively to provide good care to older people, people with long term conditions and people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice had a patient participation group that took an active role in developing and improving patient services.
- The practice could demonstrate improved outcomes for patients through the use of a range of clinical audits.
- The partners provided strong and clear leadership which had led to a committed and motivated staff group.
- The practice was responsive to its different patient groups and patients were overwhelmingly satisfied with the service they received.
- The results from the practice satisfaction survey showed that 92% of patients said they were very satisfied with the care they received

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 at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all 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 England Local 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.

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

Summary of findings

practice responded quickly to issues raised. We saw that the practice tracked complaints and incidents and the outcome from these was shared with staff. Where relevant we saw the practice implemented changes to reduce the risk of reoccurrence.

Are services well-led?

Good

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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 78% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five members of the patient participation group (PPG) on the day of the inspection and reviewed 34 completed CQC comment cards. All the comments made by patients were positive about their experience at the GP practice. PPG members were confident they could speak with the practice management and influence change. We were told all staff treated patients well and were good at their jobs. Patients felt they could influence their care and were involved with treatment and referral decisions.

We also spoke to seven patients on the day of the inspection. All of the patients we spoke with told us they were satisfied with the care provided by the staff at the practice and their dignity and privacy was respected at all times.

Shepherds Spring Medical Centre

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 specialist advisor and a GP practice manager specialist advisor.

Background to Shepherds Spring Medical Centre

Shepherds Spring Medical Centre provides primary medical services to patients living in and around Andover, Hampshire. The practice is a purpose built building. All consulting rooms are on the ground floor and there were three treatment rooms. The surgery has its own patient car park with easy access for patients with disabilities. The practice houses attached staff including district nurses, health visitors and a midwife all of whom provide clinics within the surgery.

A team of five GPs, three nurses, two health care assistants, a practice manager and a number of receptionists and administrative staff provide care and treatment for approximately 10,300 patients. There are two male GPs and three female GP at the practice to provide patients with a choice of who to see. They do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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

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?

Detailed findings

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)

Before carrying out our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We spoke with members of the patient participation group. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. We carried out an announced inspection on 6 November 2014. During our inspection we spoke with three GPs, two nurses, two receptionists, the practice manager and seven patients. We observed how patients were cared for. We reviewed 34 patient comment cards sharing their views and experiences of the practice.

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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda and a dedicated meeting was held to review actions from past significant events and

complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system she used to manage and monitor incidents. We saw that records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. National patient safety alerts were disseminated by way of the weekly 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. We saw from meeting minutes that alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Staff within the practice had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults. Records demonstrated liaison with partner agencies such as the police and social services.

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. 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 clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. 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 there after annual updates.

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

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, the vaccine fridge thermometer and nebulisers.

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 such as through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Good

Are services safe?

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.

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, 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.

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 GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen 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. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this and changed some of its procedures accordingly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (Anaphylaxis is a sudden allergic reaction) and hypoglycaemia (Hypoglycaemia is a condition characterised by an abnormally low level of blood sugar (glucose). 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, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electrician to contact in the event of any failure of electrical equipment.

The practice had carried out a fire risk assessment 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.

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, the implications for the practice's performance and patients were discussed and required actions agreed. 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 lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses 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, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients. For instance the use of managing urgent referrals for suspected Cancer (Two-week waits). We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice 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. The practice told us they were moving to a electronic referral service later in the year which will assist the monitoring of referrals in the future.

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 include data input, clinical review scheduling, adult and child safeguarding alerts, management and medicines management.

The practice showed us nine clinical audits that had been undertaken in the last year. The audit log showed the dates on which follow up audits would begin to complete the cycle. We reviewed one recent completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example, the audit examined the quality of care received by patients with coronary heart disease.

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 of patients taking a particular medicine who had coronary heart disease or uncontrolled high blood pressure. The medicine had been identified as inappropriate for these patients in a recent safety update. As a result, the practice was able to prescribe an alternative medicine to affected patients.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 90% of patients with diabetes had an annual medication review. The practice met all the standards for QOF in diabetes, asthma, and chronic obstructive pulmonary disease (lung disease). The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

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 the latest prescribing guidance was being used. The computer 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

Good

Are services effective?

(for example, treatment is effective)

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.

Effective staffing

The practice had a low turnover of staff across both clinical and non-clinical teams. Newer staff had completed a comprehensive induction and told us they felt well supported throughout. All staff felt supported by both their direct line manager and their peers. The atmosphere in the practice was positive and friendly.

Revalidation of GPs was introduced in 2012 to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Revalidation requires GPs to provide evidence that they work within robust local systems that support high quality care. One of the five GP partners had been revalidated in the last two years with the remaining four due to be revalidated in the next two years. All GPs working at the practice had revalidation scheduled and each GP had been receiving annual appraisals.

The practice had a whistle blowing policy and staff were aware of how to use the procedure if it was required. All staff knew who to speak with for specific advice. Training records indicated clinical staff received annual emergency CPR training and attended many other relevant and specific courses in their lead area. Each staff member had a list of training courses attended in the last four years.

We saw some evidence that some annual appraisals had been completed this year, but most were overdue. All staff we spoke with told us support was always available and they could request and agree additional training outside of the appraisal review process. Staff were clear about their accountabilities and their line manager responsibilities. Nurses told us clinical supervision was available as and when they requested it.

Working with colleagues and other services

Community teams were based in the practice building and shared staff room facilities. Professional relationships had developed across the teams to better provide holistic treatment to the patients of the practice. Community matrons, health visitors and district nurses were invited to and attended practice meetings.

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and processing 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 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 which were not followed up appropriately.

A quarterly palliative care meeting took place attended by community matron, district nurses, MacMillan Nurse and the relevant community team including the local hospice staff. Palliative care and end of life information including preferred priorities of care were shared with the out of hours service as required. Sharing information of this type helped ensure patients received the care they wanted at the end of their life.

Information sharing

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with. Blood and X-ray results were received electronically. These were reviewed and appropriate action taken. The practice used special notes to ensure that the out of hours service were also aware of the needs of patients receiving end of life care when the practice was closed.

Hospital discharge, A&E, outpatients and discharge letters were received in electronic format. Once the practice received the letters they were allocated to the most appropriate doctor and followed up the same day.

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient information with other services allowed external services to work with patients as soon as possible. For example, sharing known allergies. Patients were given details of how to opt out of the service and restrict access to their summary care record.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We saw a minor surgery audit for 2013/14 had been carried out at the practice which included consent to treatment. The audit demonstrated that 100% of minor surgery procedures carried out on patients had written consent in place.

We saw signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the Gillick competency test (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) For example, when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Staff we spoke with had received training in the Mental Capacity Act 2005 and could demonstrate knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We saw examples of how young people, patients with a learning difficulty, mental health difficulty or dementia were supported to make decisions. For example, there were easy read leaflets and health action plans to enable patients with learning difficulties to understand their planned treatment and care.

When patients did not have mental capacity the staff we spoke with gave us examples of how the patient's best interest was taken into account and recorded in their personal notes.

Health promotion and prevention

We saw that people had access to a range of information leaflets and posters in the waiting room about the practice and promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare. Health promotion is important because it supports patients to take responsibility for their own health and can help prevent illness in the future.

The practice offered all new patients registering with the practice and patients aged 40-75 years old a health check with the practice nurse. Well women and well men checks were available for patients on request. The practice nurse carried out weekly vaccination sessions for children in line with the Healthy Child Programme. We saw that the percentage of children who had received the appropriate vaccination at the appropriate time ranged from 90-100% which was in line with the clinical commissioning group (CCG) local average. A travel vaccination programme was also carried out at the practice.

Family planning services were provided by the practice for women of working age. Three GP's and one practice nurse were trained in performing cervical smears.

The practice nurses offered healthy living advice and support to patients. This included referrals to weight watchers and physical activity exercise classes for patients who needed a weight management programme. All patients with a learning disability were offered an annual physical health check and provided with healthy living advice leaflets in an easy read format.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The shingles vaccination was offered according to national guidance for older people.

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. A survey of 270 patients was undertaken by the practice's patient participation group. 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 that 86% of patients described their overall experience at the practice as good or very good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 34 completed cards and the majority 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. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice 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 consultation rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a patients' charter available in reception. The charter outlined the expectations patients should have from their GP including access to treatment and for their privacy to be consistently upheld. We saw a number of staff patient interactions on the day and found the staff to be pleasant at all times. It was evident good relationships were formed with patients at the practice.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. This included staff working at the reception desk dealing with phone calls and patients attending practice switchboard was located away from the reception desk which helped keep patient information private.

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 82% of practice respondents said the GP was good at involving them in care decisions and 88% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 92% of patients said they were very satisfied with the care they received.

Patients who had taken someone into an appointment with them for support or had supported someone else in their appointment, told us this had been beneficial and encouraged by staff. GPs told us they involved carers and family members when explaining specific treatments if they were at the appointment with the patient.

Patient/carer support to cope emotionally with care and treatment

The waiting area had available information for dealing with bereavement. From practical steps to take to managing grief. Staff we spoke with showed an understanding and empathy when discussing bereavement and were confident in how to deal with patients faced with this type of loss.

Support group information for health conditions was available in reception and the practice referred to Help Direct (a voluntary organisation) for more practical support with general living including housing and benefits.

The practice had a carers' notice board offering support and advice. A carers' register was kept both for patients who were carers and for patients who were cared for.

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.

The NHS England Local Area Team (LAT) 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. There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions.

The practice reviewed suggestions for improvements to the way it delivered services as a consequence of feedback from the patient participation group (PPG). We saw the practice's written response to a suggestion about how to improve the telephone system at the practice.

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice also had access to a translation service to translate medical letters received in a foreign language.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The surgery building was fully accessible to patients with mobility aids and all consulting rooms were on the ground floor.

The practice had a system in place to alert staff to any patients who might be vulnerable or who had special needs. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need as necessary.

Access to the service

The practice opened 8.30am to 12.30pm and 1.30pm to 6.30pm Monday to Friday and offered extended hours appointments every Thursday from 6.30 – 7.30 pm and every other Saturday from 9.00 – 12.00. 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. This was provided by an out-of hours service. 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. They confirmed that they could see a doctor on the same day if they needed to. They also told us that they could see another doctor if there was a wait to see the doctor of their choice, however they said appointment times sometimes over-ran. A number of comments we received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice

The practice's opening hours until 6.30pm Monday to Friday were particularly useful to patients with work commitments. Telephone consultations were used where appropriate and support was given to enable people to return to work.

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

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. There was a complaints leaflet in the waiting room and the process was also described on the practice website. 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. We looked at the complaints log for the last twelve months and found that these were satisfactorily handled and dealt with in a timely way.

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.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. The document said that the practice aimed to provide a supportive environment in which to work and delivered high quality health care through a well organised and happy team. The document was given to everyone who expressed an interest in working at the practice.

We spoke with six members of staff and they were all familiar with the values and knew what their responsibilities were in relation to these.

We saw evidence in meeting minutes that the practice was actively considering the impact on its services of a new housing development close by and was thinking about priorities for the coming year.

Governance arrangements

The practice had administrative leads for clinical and non-clinical areas including infection control and medicines management. Protocols and procedures were available to staff to manage the day to day business. Policies were held centrally on a shared drive and were updated at least annually. When policies were changed as a consequence of an event it was shared with the team within practice meetings. Administration staff had annual refresher training on practice policies and procedures to ensure they understood protocols the clinical team worked to.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. The partners also met weekly to discuss any clinical issues that the practice was facing. We saw that these meetings had a clear agenda and were fully recorded. The most recent meeting discussed training and rota issues.

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 with national standards. We saw that QOF data was regularly discussed by clinicians at the practice.

Leadership, openness and transparency

The staff could describe a clear leadership structure and knew who the lead clinicians were in each major area. For example, there was a lead nurse for infection control and the partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and staff induction policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

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

The practice had an active patient participation group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The partners at the practice told us that they greatly valued the independence of their PPG and the constructive criticism it shared with them. They believed the PPG feedback provided the practice with an invaluable perspective in helping to provide patient care.

The practice had gathered feedback from patients through an annual patient survey organised by the PPG. The survey asked patients to rate and comment on their experience of each of the GPs in the practice. The results were shared with all patients and staff via notice boards and the practice web site.

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.

Are services well-led?

Good

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

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 and that they had regular staff training sessions where guest speakers and trainers attended.

The practice take two Oxford medical students for work experience for a week each in October every year.

Significant events were discussed and lessons learnt agreed and shared within the team. We were told by all staff that the ethos of the practice was one of continued development and it strived to be the best it could. Annual reports were made on significant events, complaints and audits undertaken to identify themes and trends to action as required.

We were shown evidence that staff in all roles were provided with a thorough induction process. We saw that staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date.