Ross Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ross Road Medical Centre on 25 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for all the key questions and for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, for example, a birth and vulnerable patients' registers to track patients at risk.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw one area of outstanding practice:

- The GPs reviewed and audited every cancer diagnosis. The practice's identification and detection rate was higher than the CCG average. Specifically, cancer identification was 2.46 compared to the local average of 1.87 and the detection rate was 72.7% compared to the local average of 46.5%.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe in clean premises.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients and monitored through frequent audits. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. For example, local cancer data and found the practice was in the top 20% of local practices for its identification and cancer detection rates. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Some patients found it difficult to phone the practice to obtain an appointment. The practice constantly reviewed its access to appointments and had made improvements by introducing telephone appointments and online access to booking appointments. 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice had a business plan in place and was working to develop the practice to meet the needs of its increasing list size. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a supportive patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

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 patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. 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. Fifty patients who had been identified all had a care plan in place to manage their needs. 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. The practice had identified 124 diabetic patients, all of whom had reviews in the last year. The majority of patients with other long term conditions had received annual reviews of their condition: For example, 93.9% of patients with chronic obstructive pulmonary disease (lung disease) and 87.2% of patients with asthma.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had a significantly higher proportion of patients under the age of four years. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances, this was through their registers of birth and vulnerable patients. Immunisation rates were slightly higher for all standard childhood immunisations than the local average. 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 and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice's performance for cervical smear uptake was 79.4%, which was above average for the CCG area, although slightly below the national target of 80%.

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 all six 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice worked with the community mental health team in the case management of people with severe mental health conditions. Out of 20 patients 14 had care plans reviewed and five patients identified with dementia had care plans in place.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The most recent national GP survey data (January 2015) for Ross Road Medical Centre based on 99 completed surveys (27% response), showed good satisfaction. For example, 82% of respondents rated their overall experience of the surgery as good and 70% would recommend the surgery. The practice achievement across all areas was above or in line with the local average except for patients' experience of making an appointment including phoning the surgery to make an appointment.

The practice's own 2015 patient survey also showed positive results. All patients were very or fairly satisfied with the care provided by the practice and 82% would recommend the practice to someone moving into the local area.

We spoke with 12 patients during the inspection. All the patients we spoke with were positive about the care and treatment they received. They told us staff provided compassionate care.

We received 41 comments cards from patients. All the comments were positive and referred to the kindness and consideration of GPs, nurses and reception staff. Six cards included comments relating to difficulty in obtaining appointments.

Outstanding practice

- The GPs reviewed and audited every cancer diagnosis. The practice's identification and detection rate was higher than the CCG average. Specifically, cancer identification was 2.46 compared to the local average of 1.87 and the detection rate was 72.7% compared to the local average of 46.5%.

Ross Road 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 and an Expert by Experience. Experts by experience are members of the team who have received care and experienced treatment from similar services, they are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Ross Road Medical Centre

Ross Road Medical Centre is located in a converted detached house in a small town in Berkshire. It holds a General Medical Services (GMS) contract to provide primary medical services to approximately 2700 registered patients.

Care and treatment is led by three GPs; two male partners and one female salaried GP. They are supported by one practice nurse, one health care assistant, administration and reception staff; 10 staff in total. One of the partners was the managing partner/practice manager. The two partners also work as GP trainers at a larger local practice in a neighbouring Clinical Commissioning Group (CCG).

The practice has a lower proportion of patients in the over 50 year age group and higher in the age groups: 0 to 4 years and 25-49 years compared to the local average. The practice serves a population which is slightly more affluent than the national average. However, more deprived than the local CCG average.

The practice takes an active role within the Windsor, Ascot and Maidenhead CCG to develop services in the area.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider via 111.

We visited the practice location at Ross Road Medical Centre 85 Ross Road, Maidenhead, Berkshire, SL6 2SR

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 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

Prior to the inspection we contacted the Windsor, Ascot and Maidenhead Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Ross Road Medical Centre. We also spent time reviewing information that we hold about this practice including the action plan they provided following their previous inspection.

Detailed findings

The inspection team carried out an announced visit on 25 March 2015. We spoke with 12 patients and eight staff. We also reviewed 41 comment cards from patients who had shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and notes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Significant event reports covered a range of issues including concerns about possible child abuse, prescribing decisions and delays to diagnoses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. This information was collated in the practice significant events register. There were records of 17 significant events that had occurred during the last 18 months and we were able to review these. Significant events were discussed at monthly clinical meetings to review actions and learning. There was evidence that the practice had learned from these and that the findings were shared with all 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 and sent completed forms to the practice manager. We saw the system in place to track incidents to ensure they were monitored and managed in a timely manner. We reviewed a sample of significant event reports that had been identified and recorded in the previous 18 months. The practice encouraged reporting of significant events including positive events and used learning to improve patient safety. There were no recurrent themes identified in the significant events. We found they had been completed by GPs, nursing staff and administration staff on a range of incidents. For example, the vaccine fridge broke down and appropriate action was taken in response, another event involved a change to practice in the way patients were informed of a new diagnosis of diabetes.

National patient safety alerts were disseminated by the practice manager to practice staff. Nursing staff we spoke with confirmed they received alerts and took the appropriate action.

We saw evidence of shared learning at the monthly practice meetings. A recent incident involved a rare presentation of a common acute condition. The practice had discussed this case with their associate practice and also considered it significant enough to report it to NHS England.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures consistent with the local clinical commissioning group (CCG) and Local Authority guidelines were in place to protect children and vulnerable adults.

Safeguarding information, including local authority contacts, were accessible on the practice intranet. Staff demonstrated an understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. All staff had received training in safeguarding children. All GPs had level three safeguarding children training. Reception staff and GPs gave us examples of where they had raised concerns about patients' safety, both children and adults in and outside the practice. There was a system to highlight vulnerable patients on the practice's electronic record system.

There were notices in the waiting area and consultation rooms to remind and prompt patients to request a chaperone if desired. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff who undertook chaperone duties had disclosure and barring service (DBS) checks in place.

Medicines management

We checked medicines kept in the treatment room and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice nurse had carried out audits of the cold chain and storage of refrigerated medicines in the last year. Both audits showed compliance with the practice procedures.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked a random sample of medicines and found they were all within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. The practice received up to date directions from the CCG and nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw the practice had carried out a number of audits to monitor checks were carried out when these medicines were prescribed. For example, regular blood tests were taken and acted upon appropriately.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank computer prescription forms were stored securely, however, the recording of these blank forms was not in accordance with national guidance as these were not tracked through the practice. The pre-printed forms were stored securely and were tracked when issued.

The practice carried out medication reviews and showed us 89% of all patients on four or medicines had a medication review and 81% of patients on repeat medicines. We saw seven audits on prescribing had been undertaken by a pharmacist from the local medicines optimisation team since September 2014. The practice was acting on the recommendations where appropriate. The practice regularly reviewed its prescribing at monthly meetings and was aware of the areas where its performance was below the CCG average. We found the practice performed less well in relation to antimicrobial prescribing; the practice was working to improve this, we saw a number of notices in the waiting room informing patients about when antibiotics may not be appropriate and the development of antibiotic resistance.

Cleanliness and infection control

We observed the premises were 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. Daily cleaning schedules were followed and monitored. We saw evidence that when issues were identified they were raised with the cleaner.

Systems were in place to reduce the risks of spread of infection. One of the practice nurses was the infection control lead for the practice. They demonstrated a good understanding of their role. All staff had received training in infection control and were aware of infection control practices. For example, we observed staff used personal protective equipment such as gloves and saw that they disposed of clinical waste safely.

The practice infection control lead carried out six monthly infection control audits. Our review of the last audit showed good adherence with infection control procedures. The latest action plan included regular hand hygiene training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were aware of how they would use these to comply with the practice's infection control policy. For example, when accepting urine samples from patients. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The chairs in the waiting room had wipe clean surfaces. All areas of the practice clean and well maintained.

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. The practice had carried out a legionella risk assessment in 2014 and regularly checked water temperatures, although these were not always recorded.

Equipment

Staff we spoke with told us they had sufficient 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 planned maintenance and testing schedule was followed. Regular checks on the premises and equipment were in place to ensure they were fit to use. For example, annual service checks on gas and annual calibration checks on medical equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed a sample of five files which confirmed the required pre-employment information had been sought. These included all the required information including a curriculum vitae or application form, one or two references, occupational health check, photographic identity, professional registration check and criminal records checks through the Disclosure and Barring Service (DBS). New staff underwent an induction and probationary period at the start of their employment.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The managing partner ensured there was sufficient staff on duty at all times. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and available for annual leave and sickness absence cover. One locum was employed to cover maternity leave and GPs from an associate practice provided cover in an emergency. This ensured familiarity with practice procedures and a degree of continuity of care for patients.

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. Staff were aware of the location of the practice accident book and used it to record accidents if they occurred.

The practice had considered the risks of delivering the service to patients and staff and had implemented systems to reduce risks. For example, the practice maintained a risk register to record and manage risks. This showed who was responsible for individual issues and how they were tracked.

We observed the practice was organised and tidy. We saw the provider had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. For example, in relation to staffing, premises, fire and environmental issues such as inclement weather. The practice had introduced CCTV camera for the car park to improve security after staff had raised concerns.

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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Fortnightly checks of emergency medicines took place to ensure they were within their expiry date and suitable for use.

Good

Are services safe?

The practice business continuity plan had recently been reviewed. The document detailed the range of emergencies that may impact on the daily operation of the practice and the arrangements in place to manage the situation. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The plan included relevant information for staff to refer to. For example, contact details of key personnel and essential suppliers.

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 notes 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 led in specialist clinical areas such as diabetes and dermatology. GPs we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines as part of their monthly clinical meetings.

We reviewed prescribing data from the local clinical commissioning group (CCG). Ross Road Medical Centre fully participated in all the elements of the local prescribing incentive scheme 2013/14. We found the practice performed less well in relation to antimicrobial prescribing and the practice was working to improve this, we saw a number of notices in the waiting room informing patients about when antibiotics may not be appropriate and antibiotic resistance.

The practice used computerised tools to identify patients with complex needs. The practice identified 50 patients with complex needs who were at greater risk of admission to hospital. The practice ensured all these patients had a care plan in place and priority access to a GP. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be contacted within three days of discharge from hospital.

CCG data showed the practice was in line with expected referral figures and emergency admissions were slightly better than the CCG average. The practice regularly reviewed its referral data at monthly clinical meetings. CCG data showed Ross Road Medical Centre referrals were in line with the CCG average but emergency admissions were lower than average.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Regular searches were carried out on the disease registers of patients with long term conditions. These identified patients who had not attended for regular reviews and they were followed up with recall appointments to encourage attendance.

Both GP partners were GP trainers at their associate practice and they demonstrated a strong culture of audit. We saw a number of focussed, relevant audits including annual repeat audits which showed year on year improvement in, for example, prescribing practice. Monthly clinical meetings were held to discuss audit findings. The practice showed us 12 clinical audits that had been undertaken in the previous 12 months. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One audit showed three cycles of the audit and all the re-audits demonstrated improved prescribing and clinical practice at each cycle. For example, the prescribing of a particular antibiotic when kidney function was low was shown to be reduced at the second cycle. Another audit showed an improvement in checking new mother's blood glucose levels at the post-natal check and annually if they had been diagnosed with gestational diabetes.

Clinical audits had been undertaken which showed the practice measured its performance against current best evidence and demonstrated adherence to current guidelines to monitor changes in practice and outcomes for patients. For example, clinical audits were often linked

Good

Are services effective?

(for example, treatment is effective)

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.

The practice achieved 100% in the clinical domain of the Quality and Outcomes Framework (QOF) and 100% overall in the previous year. The practice was on track to achieve similar results this year (2014/15). The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had identified 124 patients with diabetes. The majority of patients with long term conditions had received annual reviews of their condition: 93.9% of patients with chronic obstructive pulmonary disease (lung disease) and 87.2% of patients with asthma. GPs worked with the community mental health team to develop care plans for patients with severe mental health conditions. Out of 20 patients 14 had care plans reviewed. Patients who were housebound due to mental illness were visited at home for health checks and blood tests. This contributed to the practice's high QOF achievement in this area. Five patients with dementia had care plans in place. The practice had identified the number of patients with dementia was lower than expected for the practice. In response it had contacted the local memory clinic and was reviewing its coding to ensure patients were identified correctly. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance and support their GPs and nursing staff. Monthly clinical meetings included discussion and review of referral data and emergency hospital admissions.

The practice had developed its own intranet system which included registers for audits, births, deaths, cancers and vulnerable patients. Our review of the birth register showed it contained information such as breast or bottle feeding and maternal psychosocial issues. The practice had the second highest proportion of patients under the age of four years and clearly saw this as an area of focus. They had invited the health visitors to work with them to support patients at higher risk. The practice cancer register showed extensive coding and the progress of the patient's treatment. We reviewed local cancer data and found the practice was in the top 20% of local practices for its identification and cancer detection rates. Specifically, cancer identification was 2.46 compared to the local average of 1.87 and the detection rate was 72.7% compared to the local average of 46.5%.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, administrative and reception 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 noted a good skill mix among the doctors with one GP who had a special interest in diabetes and rheumatology and another in dermatology. All GPs were up to date with their yearly continuing professional development requirements and one had been revalidated and the others had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which development plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, the recently appointed healthcare assistant had undergone a range of training to develop her skills to meet the needs of patients and complement the skills of the practice nurse.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

The locum GP was supported by the GP partners informally and formally through audit.

Working with colleagues and other services

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

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly multidisciplinary team meetings to discuss the needs of patients with complex medical needs, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Discussion of palliative care patients followed the Gold Standards Framework for end of life care. The Gold Standards Framework is a systematic evidence based approach. It is designed to assist healthcare professionals to optimise care for all patients approaching the end of life.

The practice worked with community midwife service and with the health visitors to care for mothers and babies.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, the practice used 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 registration information included information on electronic patient records. The practice used the electronic Summary Care Record (SCR) and offered patients access to their electronic GP record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Administrative staff confirmed they printed the SCR for patients to take with them to hospital if needed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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 GPs were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. The GPs described examples of where they had considered capacity issues and sought advice from the local memory clinic and psychiatric team.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All those patients had a care plan in place. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated

Good

Are services effective?

(for example, treatment is effective)

a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice was aware of the local health priorities and more specifically in relation to their practice population. Antenatal care was shared with the community midwife and GPs carried out the new baby checks.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years, carried out by the health care assistant. Patients were followed up promptly if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all six patients had an annual review of their condition so far this year. The practice performed above the CCG average for its smoking cessation service. It had identified the smoking status of 91.9% of patients over the age of 16 and 99% had been offered smoking cessation advice.

The practice's performance for cervical smear uptake was 79.4%, which was above average for the CCG area. Patients who did not attend for screening were followed up by the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was slightly above the CCG average for 12 months at 92.7% and 94.8% at 24 months. CCG data was 92.3% and 92.7% respectively. The practice had a clear policy for following up non-attenders by the GP. The practice achieved 75.8% flu vaccine uptake in over 65 year olds in the previous year which was above the CCG average of 73%.

There was a large quantity and wide range of information in the waiting room noticeboards and on the practice website, aimed at patients for health promotion and self-care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The most recent national GP survey data (January 2015) for Ross Road Medical Centre based on 99 completed surveys (27% response), showed patients were generally satisfied with the services provided. For example, 82% of respondents rated their overall experience of the surgery as good and 70% would recommend the surgery. The practice achievement across all areas was above or in line with the local average except for patients' experience of making an appointment including phoning the surgery to make an appointment. The proportion of patients who stated staff were good at treating them with care and concern was 91% for doctors, higher than the CCG average of 82%. Patients were also satisfied with the good listening skills of both GPs (90%) and nurses (88%).

The practice's own 2015 patient survey also showed positive results. All patients were very or fairly satisfied with the care provided by the practice and 82% would recommend the practice to someone moving into the local area.

We spoke with 12 patients during the inspection. They were a mix of patients, male and female, parents with young children and older patients. We also spoke with two representatives of the patient participation group (PPG). All the patients we spoke with were extremely positive about the care and treatment they received. They told us all staff treated them with respect and kindness.

We received 41 comments cards from patients. All the comments regarding the care received from the practice were positive and some included specific examples of compassionate care and many referred to the consideration of GPs, nurses and reception staff.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception desk was located away from the waiting area. Private space was available if needed to accommodate waiting patients, for example if they were potentially infectious.

All staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, during the inspection we witnessed numerous caring and compassionate interactions between staff and patients which demonstrated how staff treated patients with dignity and respect.

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 77% of practice respondents said the GPs were good at involving them in decisions about their care and 90% said GPs were good at explaining tests and treatment, compared to 80% and 84% for nurses, respectively. Both these results were above average compared to the CCG area.

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

Patients preferred methods of communication was recorded and the practice sought the patients consent before messages were left on answerphones.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were very positive about the emotional support provided by the practice. Bereaved patients were contacted by their named GP to offer support.

A list of palliative and vulnerable patients was updated daily. Staff were aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed.

A number of notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice demonstrated a thorough understanding of their registered population.

A phlebotomy (the process of taking blood from patients) service was offered three times a week. The practice offered its patients a travel clinic service.

The practice valued the role of their patient participation group (PPG). We reviewed the feedback from the 2014 annual survey. The majority of feedback was positive and suggested improvements included extended opening hours and online repeat prescription requests. Both of which had been implemented.

Tackling inequity and promoting equality

The practice has a lower proportion of patients over the age of 50 and higher in the age groups: 0 to 4 years and 25-49 years compared to the local average. The practice served a population which was slightly more affluent than the national average. However, more deprived than the local CCG average.

Average life expectancy for males and females was slightly higher than the national average. Data on the ethnicity of patients was not available. However, we were told that the practice had a more diverse patient list than other practices in the area.

Staff told us that translation services were available for patients who did not have English as a first language. However, staff confirmed the facility was very rarely used as the majority of patients could speak English and both GPs could speak other languages.

The practice maintained a register of all patients with a learning disability. One hundred per cent of patients on the register had annual reviews of their condition in 2013/14 and all six patients had an annual review of their condition so far this year.

The patient areas of the practice were all located on the ground floor of the premises and there was disabled access to the practice. 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.

Access to the service

The practice was open daily from 8.30am to 1pm and 2pm to 6pm, except for Tuesdays when there was no afternoon opening. Extended surgery hours were provided on Wednesday evenings until 7pm. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Longer appointments were available for people who needed them and those with long-term conditions. Patients on the 'unplanned admission' register had a priority access to appointments or to speak to a GP.

We spoke with 12 patients; generally they were satisfied with the appointments system. Although, three patients and six of the 41 comments from cards made reference to sometimes experiencing difficulty in obtaining appointments. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments 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. On the day we visited, patients told us they were able to obtain urgent and routine appointments when needed and our review of the appointment system confirmed this. The practice was aware that some patients had difficulty accessing appointments and the managing partner regularly monitored the situation as the practice list size increased. The practice had also reviewed its patients' use of the out-of-hours service and it had not found any increase in use when the practice was closed on Tuesday afternoons.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Data from the national patient survey showed the practice performed less well on access to appointments: 50% of respondents said they found it easy to get through to this surgery by phone compared to the local average of 70% and 55% of respondents described their experience of making an appointment as good, compared to 67%. The practice had responded by taking steps to improve telephone access and number of slots available for on line appointments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the practice waiting area and website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the 12 patients we spoke with or the 41 comment cards we reviewed mentioned ever making a complaint against the practice.

We looked at the annual complaints review March 2014 to February 2015. No complaint had been escalated to the Ombudsman. Our review of the complaints register had been appropriately and there was evidence of reflection and change to practice noted. We reviewed a sample of complaints in detail and they showed the GP partners had taken the patient's complaint very seriously, carried out a thorough investigation and provided a detailed and sensitive response to the complainant. The practice showed openness and transparency in dealing with the complaints at the monthly practice meetings.

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

We spoke with eight members of staff and they all expressed pride and a great deal of satisfaction working at Ross Road Medical Centre. The practice vision, mission and values were on display in the practice and on the website. The practice aimed to 'To be the local GP practice of choice, valuing our staff and our patients in delivering high quality, safe, effective personalised care and putting patients at the heart of everything we do.'

The GP partners demonstrated a very inclusive approach to staff and patients. For example, the practice vision had been developed collaboratively with patients and staff. The name of the practice had also been changed with input from patients and staff, when the partners took over the practice in 2010.

The Ross Road Medical Centre business plan 2015-18 included its vision and values and how the practice aimed to further develop the practice, for example as both GP partners were trainers, they aimed to apply for training accreditation in the next year.

The practice worked collaboratively with the local clinical commissioning group (CCG) to identify priority areas and develop services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer or in hard copy. We looked at five of these policies and procedures. All five policies and procedures were up to date. There was an office manual and workflow trays for all staff, to facilitate effective working. Policies and procedures were easily accessible on the practice intranet.

There was a clear leadership structure with named members of staff in lead roles. For example, one of the partners was the lead for safeguarding and another for clinical governance and practice nurse for infection control. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had achieved 100% in the clinical domain of the Quality and Outcomes Framework (QOF) and 100%overall in the previous year. The practice was on track to achieve similar results this year (2014/15). We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had carried out a range of audits which it used to monitor quality and systems to identify where action should be taken.

The practice had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

The practice had arrangements for identifying, recording and managing risks. We saw risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered partners meetings, clinical meetings and practice meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively. We looked at notes from the last three meetings and found that performance, quality and risks had been discussed.

The practice held monthly clinical meetings where GPs and nurses discussed clinical issues including referrals and obtained support from colleagues.

The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

Leadership, openness and transparency

All staff spoke highly of the practice leadership. Staff were supported to develop in their roles and encouraged to raise issues for learning and improvement. We saw from minutes

Are services well-led?

Good

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

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.

All staff wore uniforms and name badges, their pictures and names were on display on the video presentation in the practice waiting room and website.

The managing partner was responsible for human resource policies and procedures, contained within the staff handbook. We reviewed a number of policies, for example, recruitment, confidentiality and whistleblowing, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

All staff spoke about a desire to provide high quality, patient centred care. The practice benefited from dedicated staff who described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education and learning for all staff.

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

The patient participation group (PPG) consisted of two members, a third person had recently left the group. We spoke with two representatives of the PPG. They were very enthusiastic about their roles and were committed to working with the practice to improve services. The PPG held meetings with the practice every three months to discuss issues, for example, the 2015 patient survey results. We saw the annual survey results and action plans for the last four years were published on the practice website. Actions had been implemented to improve access to appointments which regularly featured as an area for improvement. For example, improved telephone access and introduction of booking on line appointments.

The practice welcomed feedback from the public, via a suggestion box in the reception area, NHS choices website and the NHS Friends and Family test (FFT). The FFT results for the last three months were very positive with over 90% patients extremely likely or likely to recommend the practice in December 2014 and January 2015 and 100% in the February 2015.

The practice engaged with staff informally and formally 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 gave examples of when they had raised concerns if they felt it necessary. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy.

Staff told us they felt valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed appropriately. An annual meeting schedule was in place which included significant event meetings, clinical meetings and practice business meetings.

Management lead through learning and improvement

Staff told us that the practice supported them through mandatory training updates, for example, in infection control, child safeguarding and basic life support. All staff had been appraised in the last year. Staff told us they felt the appraisal was a meaningful process and identified areas for future personal development. We saw examples of this in the staff training records we reviewed.

All the GPs mentioned the practice's focus on education and learning through its audit programme and review of significant events and other incidents. The learning was shared with staff at team meetings to ensure the practice continuously improved outcomes for patients.

One of the GP partners had developed the practice intranet which included accessible registers of audit, significant events, births, cancers, and vulnerable patients to improve patient care.