Practice 1, Medical Centre, Bridlington

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 this comprehensive inspection on 22 June 2015.

Overall, we rated this practice as good. We found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services for the all of the population groups we looked at.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines.
- Patients told us they were treated with dignity and respect and patient satisfaction levels were high.
- The practice performed well in the management of long term conditions and was proactive in offering review and screening services.
- Patients could access appointments without difficulty and were happy with the telephone and repeat prescribing systems.
- The building was safe for patients to access, with sufficient facilities and equipment to provide safe effective services.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.

However there are also areas were the provider needs make improvements. The provider should:

- Improve on structured meetings for all staff
- Improve the clinical audit information sharing process to ensure that it informs and improves clinical and operational practice

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 their roles and responsibilities in raising concerns and reporting incidents. Lessons were learned from incidents, although practice wide meetings were not always undertaken so there was some potential for learning opportunities to be missed. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency and contingency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook some audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently positive. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. In patient surveys, the practice scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern and felt involved in their treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population and provided services to meet these needs. The practice had good facilities and was well equipped to meet patients need. Information was provided to help people make a complaint and there was evidence of shared learning with staff. Patients told us they had no problems getting an appointment, with urgent appointments available the same day. The practice scored highly in patient surveys for the convenience of appointments.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were able to describe how they would work to provide effective care and support to patients, which reflected the practice's culture and values. Staff described colleagues, the GPs and practice manager as available and approachable. There were systems in place to monitor quality and identify risk. The practice had a number of policies and procedures to govern activity and staff know how to access these. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of feedback.

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. The practice held multi-disciplinary meetings to ensure the needs of those with chronic conditions or end of life care were met. Care plans were tailored to meet individual needs and circumstances. Patients and their carer's were involved in this process. The over 75's had a named GP. Information was shared with other services, such as the out of hours service. The practice also provided a direct line telephone number for care homes where a resident was at risk of admission. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. It also performed better than the national averages for the percentage of patients over 65 who received a seasonal flu vaccination.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and clinicians at the practice responded to their changing needs. Clinical staff had obtained qualifications in specific disease areas and the care was based on the latest care and treatment guidelines. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. The practice was aware of the number of patients it had with two or more chronic conditions and invited them to clinics held regularly at the surgery. People with conditions such as diabetes and asthma attended regular nurse clinics, longer appointment times were available if needed to ensure their conditions were appropriately monitored. People were involved in making decisions about their care. The practice routinely followed up non-attenders to ensure they had the required routine health checks. The practice nurses would also undertake home visits to patients with long term conditions who were unable to attend the surgery.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk, those on a child protection plan or looked after children. The practice monitored levels of children's vaccinations and immunisation rates were in line with the national average for childhood immunisations. Full post natal and week baby checks were carried out by one of the GPs.

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). Routine appointments could be booked up to 12 weeks in advance, or made online. Repeat prescriptions could be ordered online and delivered to a nominated pharmacy. GP and nurse practitioner telephone consultations were available for some medical reviews, results and advice.

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 had a register of those who may be vulnerable and the practice used the patient records to identify if they required additional support. Patients or their carer's were able to request longer appointments if needed. There was a register for looked after or otherwise vulnerable children and the practice worked with school nurses to follow up if any routine appointments were missed. The practice undertook annual health checks for patients with learning disabilities. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns and the practice had a dedicated safeguarding administrator to ensure that critical information was shared appropriately.

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). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. For instance, 90% of patients diagnosed with dementia had their care reviewed in the last 12 months, which was above the national average of 83%. The practice also enabled patients to refer themselves for counselling or to the Crisis Team.

Summary of findings

What people who use the service say

In the latest NHS England GP Patient Survey of 123 responses, 93% of patients reported their overall experience as good or very good. 86% said the GP was good at involving them in decisions about their care, while 88% said their GP was good or very good at treating them with care and concern. 100% said that they had trust and confidence in the last nurse they spoke to. These results were all above the Clinical Commissioning Group (CCG) average.

Overall patients were satisfied with the appointments system. 76% of patients said it was easy to get through on the phone, 98% said that the last appointment they had was convenient and 81% described their experience of making an appointment as good. Again, these results were above average.

Results which were slightly below average included 88% of patients who said the last GP they saw or spoke to was good at listening to them, and 86% of patients who said the last GP they saw or spoke to was good at giving them enough time.

We spoke to a member of the Patient Participation Group (PPG) and three patients as part of the inspection. We also collected seven CQC comment cards which were sent to the practice before the inspection, for patients to complete.

All the patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity and respect and that staff were friendly and caring. Patients said that their needs were responded to and they received the care that they needed. Patients said they were treated as individuals and involved in their care.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Improve on structured meetings for all staff
- Improve the clinical audit information sharing process to ensure that it informs and improves clinical and operational practice.

Practice 1, Medical Centre, Bridlington

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 specialist advisor GP, and a Practice Manager.

Background to Practice 1, Medical Centre, Bridlington

The Practice 1 Medical Centre Bridlington provides Personal Medical Services to a population of 5,840 patients. Services are provided from a shared, purpose built healthcare facility at Station Avenue in the centre of Bridlington.

There are two partners and one salaried GP, two male and one female. The practice also has two advanced nurse practitioners, three practice nurses and two healthcare assistants. They are supported by a team of management, reception, administrative and cleaning staff. The practice has opted out of providing Out of Hours services and these are provided via the NHS 111 service.

The practice is in a comparatively deprived area and has a higher than average number of patients with long standing health conditions and patients in receipt of Disability Allowance.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury.

The practice is open between 8:00am and 6:00pm Monday to Friday. Appointments are available from 8:30am to 12:20 every morning and 13:30 to 17:30 in the afternoon.

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) 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?

Detailed findings

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with a member of the Patient Participation Group.

We carried out an announced inspection on 22 June 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GPs, nursing staff, administrative and reception staff.

We observed how staff handled patient attending for appointments information received from patients ringing the practice. We reviewed how the GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us a summary of significant events from the previous 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff and the GPs we spoke to were aware of incident reporting procedures. They knew how to access the forms and felt encouraged to report incidents.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found the GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed the practice was appropriately identifying and reporting significant events.

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

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed and learning points documented. We saw where actions had been taken as a result, such as communications with other healthcare providers and sharing information with the CCG.

Significant events were discussed within the practice as part of practice meetings, although the last practice meeting which had minutes produced was from February 2015. Significant events were not a standing item on the practice meeting agenda. Much of the sharing of information was from daily meetings of the GPs and regular nurses meetings. While staff said they were informed of the outcome of significant events investigations, it was difficult to evidence that all opportunities for learning had been taken.

We could see from a summary of significant events and complaints that where necessary the practice had communicated with patients affected to offer a full explanation and apology and told what actions would be taken as a result, or told why a request could not be processed.

National patient safety alerts were disseminated by email or via the intranet. Staff were able to give recent examples of alerts relevant to them and what action had been taken, such as a recall of equipment or changes to medication guidance.

Reliable safety systems and processes including safeguarding

The practice had up to date safeguarding children and safeguarding vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access the policies. One of the GPs was the named safeguarding lead for children and another was the lead for adult safeguarding. Administrative support for this area was provided by the senior receptionist. Staff said they would report incidents to the relevant GP.

Staff were able to describe types of abuse and how to report these. Staff had been trained in safeguarding at a level appropriate to their role.

The computerised patient records were used to enter codes for children on the at risk register. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E. Information was passed to the health visitor as appropriate.

The practice had a chaperone policy and there was information on this service for patients in reception and in the consulting rooms, although not in the practice leaflet. (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). Staff were able to explain their role in acting as a chaperone. Nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available.

Good

Are services safe?

Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature, and thermometers were calibrated yearly. Dedicated members of staff were responsible for ordering, stock checking and the cold chain procedure. There was a process for checking that refrigerated and emergency medicines were within their expiry dates.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a repeat prescribing protocol, with processes to check the issue of repeat prescriptions, medication reviews and lost or uncollected prescriptions.

Prescriptions were stored securely and there was a system in place for the GP to double check repeat prescriptions before they were generated. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

Cleanliness and infection control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC) and waste disposal policies. These were reviewed and updated regularly. There was an identified IPC lead. We saw that cleaning schedules for all areas of the practice were in place.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in treatment areas.

Sharps bins were appropriately located, labelled, closed and stored after use. A legionella risk assessment had been carried out.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw other equipment such as blood pressure monitors used in the practice was clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

We found that equipment such as spirometers, ECG machines (used to detect heart rhythms) and fridges were checked and calibrated yearly by an external company.

Contracts were in place for checks of equipment such as fire extinguishers and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager. We did find that the contents of the emergency oxygen cylinder had passed the expiry date. Staff had been carrying out visual checks on the cylinder but had overlooked the date. The practice took corrective action immediately by replacing the cylinder.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing and recruitment

Staff files 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 via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

Good

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a multi-skilled team who supported each other. There were arrangements in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Nursing staff said they could cover each other's work by working extended hours. GP holidays were covered by the other GPs working extra hours. Both of the GP partners worked eight sessions a week so would increase their sessions to cover absences.

Monitoring safety and responding to risk

Staff were able to recognise changing risks within the service, either for patients using the service or for staff and able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk. As this was a building shared with two other practices a number of the premises checks were undertaken by the building manager, but the practice manager was informed of any issues.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk. An annual health and safety assessment was carried out by the building manager.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. Information on patients was made available electronically to out of hours providers where necessary so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. There was a defibrillator available which was checked and serviced regularly. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if a patient experienced a cardiac arrest.

Staff described the roles of accountability in the practice and what actions they needed to take if an incident or concern arose, including how to summon for assistance.

A business continuity plan and emergency procedures were in place which included details of scenarios they may be needed in, such as loss of data or utilities. Weekly fire alarm checks took place and there were regular fire drills.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. Anaphylaxis kits were kept in each of the treatment rooms.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via the computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice. Clinical staff interviewed were aware of their professional responsibilities to maintain their knowledge. Nursing staff implemented long-term condition clinics flexibly, with patients able to attend a longer appointment to discuss multiple needs. The nurses attended regular updates and implemented changes as appropriate to ensure best practice. The nurses were supported by the GPs.

The practice kept up to date disease registers for patients with long term conditions such as asthma, diabetes and chronic heart disease which were used to arrange annual, or as required, health reviews. The practice was proactive in screening patients for long-term conditions.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates which were kept under review, and how patients were reviewed at required intervals to ensure their treatment remained effective. The percentage of patients with diabetes on the register, whose last blood pressure reading was less than 140/80 was 80.63% compared to the national average of 78.6%. 90.7% of patients with dementia had been given a care review within the last 12 months, compared to a national average of 83.83%. The practice encouraged patients to self-management their long-term conditions.

They also provided annual reviews to check the health of patients with learning disabilities and mental illness. The practice could produce a list of those who were in need of palliative care and support and held end of life planning discussions. Patients requiring palliative care were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

Patients with long term conditions such as diabetes had regular health checks and were referred to other services. National standards for referral were used, for instance two weeks for patients with suspected cancer to be referred and seen. The practice nurses undertook home visits for patients with long term conditions who were unable to attend the surgery.

The practice had identified their 2% of most vulnerable patients, who were at risk of an unplanned admission to hospital and had developed care plans for this group. The advanced nurse practitioner also regularly visited patients in local nursing homes to offer medical advice and support.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook some clinical audits. The practice was not an outlier for any QOF (or other national) clinical targets.

The practice had high levels of some long-term conditions, such as chronic obstructive pulmonary disease (COPD) and heart disease. The practice had a good understanding of the needs of the local population and were proactive in monitoring outcomes for these patients to improve care through its specialist nurse services.

Clinical staff were proactive in checking the clinical system to ensure that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. The practice carried out some clinical audits, examples of which included prescribing of cephalosporins and quinolones and a review of patients with gout. Cephalosporins and quinolones are antibiotics that are recommended for use in very limited scenarios to prevent the further emergence of resistance. The number of times they had been prescribed by the practice was very low and where they had been used it was either within the national and local guidelines or acceptable clinical explanations had been recorded. The review of patients with gout identified that practice could be improved as only 10% of patients with gout had serum

Good

Are services effective?

(for example, treatment is effective)

uric acid levels within the expected ranges. It was agreed that the GPs would review their practice with a further audit to be undertaken in 2015, at the time of the inspection the follow-up audit had not been completed.

Effective staffing

The practice manager ensured that training was undertaken. Information was held in a number of places, including on the on-line training system and on individual staff files. We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff had access to additional training related to their role. Staff were encouraged to identify learning and development needs which would assist them in their role and benefit the practice.

The GPs had undertaken annual external appraisals and one had been revalidated, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored as part of the appraisals process and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

Clinical and non-clinical staff had yearly appraisals, which identified individual learning needs and action points from these. Nursing staff said they were able to have regular discussions with the GPs or senior nurses for clinical supervision and best practice discussions, although much of this was informal and not recorded. Nursing staff had protected learning time (PLT).

On starting, staff commenced an induction comprising subjects such as health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

Regular multi-disciplinary meetings were held with district nurses, health visitor, Macmillan nurses and clinical staff to identify and discuss the needs of those requiring palliative care. An Advanced Nurse Practitioner (ANP) employed by a group of local practices visited patients in nursing homes on a regular basis. There was ongoing communication between the practice, the ANP and district nurses to review the care planning and needs of vulnerable patients.

Regular clinical and non-clinical staff meetings took place, although the practice acknowledged that it needed to improve the frequency of whole practice meetings. Staff described communication in the practice as generally good. The practice manager was able to meet, on an informal basis, with other practice managers in the building to share best practice.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant member of clinical staff, or where necessary a procedure for scanning documents was in place. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information sharing

Staff said that communication and information sharing was generally good. Much information sharing was informal and on a daily basis. Clinical staff said they could meet with the GPs whenever they needed to and non-clinical staff received ongoing updates and communication from the practice manager.

Referrals were completed by direct letters to the local hospital and these were completed within appropriate protocols.

There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice aimed to enter patient information such as records of home visits and hospital letters onto the system the same day.

Consent to care and treatment

We found that staff were able to describe how they would deal with issues around consent. Where those with a learning disability or other mental health problems were supported to make decisions, this was recorded.

Good

Are services effective?

(for example, treatment is effective)

We did find that not all staff had been given specific training around the Mental Capacity Act 2005. GPs had had the training but not all nursing staff had. Staff described consent issues as being covered in other training modules, such as safeguarding. However, staff were confident in discussing how they would deal with consent issues, including how they would involve parents and carers.

There was a practice policy on consent to support staff and staff knew how to access this and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent This included escalating this for further advice to a senior member of staff where necessary.

Verbal consent was documented on the computer as part of a consultation and staff were able to explain how they would discuss a procedure, detailing risks and benefits. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, this allowed patients to make an informed choice.

Health promotion and prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. There was a culture among clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers, or screening for the early signs of dementia. Carers were offered health checks. The practice had a high uptake of new patient health checks and screening checks, and sought to involve the patient in self-management of long-term conditions.

Nurses used chronic disease management clinics where patients were seen for multiple conditions to promote healthy living and ill-health prevention. Patients over the age of 75 had been allocated a named GP.

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 was in line with national averages for the majority of immunisations where comparative data was available.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes

The practice's performance for cervical smear uptake and flu vaccinations was comparable to the CCG and England averages. There was a policy to follow up patients who did not attend for cervical smears.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

In the latest NHS England GP Patient Survey of 123 responses, 93% of patients reported their overall experience as good or very good. 88% said their GP was good or very good at treating them with care and concern. 95% said the last nurse they saw was good at listening to them and treating them with care and concern. These results were all above national averages.

We spoke to a member of the Patient Participation Group (PPG) and three patients as part of the inspection. We also collected seven CQC comment cards which were sent to the practice before the inspection, for patients to complete.

All the patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity and respect and that staff were friendly and caring. Patients said they were confident with the care provide and were treated as individuals.

All the staff we spoke with told us of the caring culture within the practice. Our observations confirmed that reception staff were friendly and polite when treating patients.

The practice phones were located away from the reception desk which helped keep patient information private. If a patient wished to speak to a receptionist in private they would use one of the consulting rooms. We observed that reception staff maintained confidentiality as far as possible and music was played in the waiting area so that patients could not be overheard.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were used in treatment rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff and information available on this in reception. Patients we spoke to confirmed that they had been offered a chaperone. Nursing staff acted as chaperones where requested and other non-clinical staff had also been given appropriate training.

Care planning and involvement in decisions about care and treatment

In the latest NHS England GP Patient Survey of 123 responses, 86% said the GP was good at involving them in decisions about their care. The figures for nurses was 92% both of these were above the CCG average. 88% of patients said the last GP they saw or spoke to was good at listening to them, this was slightly below the CCG average of 92%. 89% of patients who said the last GP they saw or spoke to was good at explaining tests and treatments, which was in line with the CCG average.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff described how they discussed care planning and supported patients to make choices about their treatment. Extra time was given during appointments where possible to allow for this and multiple conditions could be discussed in one lengthened appointment.

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

Staff told us there was a translation service available for those whose first language was not English.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctor and nurses and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said the GPs and nurses provided a caring service.

When patients had suffered bereavement, they would be referred to a bereavement counselling service if required. The practice also provided contact information on a weekly lunch and social club where those who had been bereaved could meet with others in a similar situation. The practice also noted on a board in reception the names of patients who had recently died so that all staff were aware if they were dealing with a bereaved relative either in reception or on the telephone.

Good

Are services caring?

The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers and patients with mental health issues, so extra support could be provided.

For patients in need of mental health support, the practice offered self-referrals to counselling or the Crisis team. The practice also referred to other local specific services for mental health issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided.

The practice held information about the health needs of their population. For example they were able to tell us that 12% of their patient population and two or more chronic diseases. This information was reflected in the services provided, for example there were regular reviews for patients with coronary heart disease and respiratory diseases. Longer appointments were made available for those with complex needs.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as level access and treatment and consulting rooms on the ground floor. 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.

There was a practice information leaflet available. These were given out when new patients registered or could be requested from reception. It covered subjects such as services available, out of hours services and how to make a complaint. The practice also provided information on notice boards in reception about the services available.

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients complex conditions. The majority of the practice population were English speaking patients but access to translation services were available if needed. Patient records were coded to flag to the GP when someone was living in vulnerable circumstances or at risk.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training and staff confirmed that they had completed this training.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. 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.

Appointments could be made in person, by telephone or online. Repeat prescriptions could be ordered online and this was highlighted on the website and in the patient information leaflet. Patients could also register for the Electronic Prescription Service, where prescriptions could be transmitted to the pharmacy of their choice.

The practice was open from 8:00am to 6:00pm on Monday to Friday, with appointments starting at 8:30am. Opening times and closures were advertised on the practice website and in the information leaflet. Patients could generally access an urgent appointment on the same day. Pre-bookable appointments were also available. The practice would ensure that they saw unwell children on the same day.

During core times patients could access doctors, nurses and health care assistants. Patients were satisfied with their access to clinical staff. In the patient survey of the 123 responses 98% of patients said that the last appointment they had was convenient. The most common concern was that patients could not always get to see their preferred GP.

The practice also provided a direct line telephone number for care homes where a resident was at risk of admission. This improved access to the GPs and helped to reduce possible admissions.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

recognised guidance and contractual obligations for GP's in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet and staff were able to signpost people to this. Details were also on display in reception. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

We looked at a summary of complaints made during 2014, and could see that these had been responded to with an explanation and apology.

The practice carried out a patient survey in 2013-14 and worked with the PPG to implement some of the suggestions made. This included improvements to the information on notice boards in reception and promoting the on line appointment system.

There was a box in reception where patients could leave feedback through the 'Friends and Family' test and this feedback was monitored and reported. The practice also had its own suggestion box.

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 set out its aims and objectives in their statement of purpose. These included to provide good quality patient care and improve services and to ensure dignity and respect to all patients. These aims and objectives were supported by the practice values which included team-working providing individualised care and flexibility to fit around patient needs, Whilst the practice did not have an individual business plan it was an integral part of the BridInc Project. This three year project was to develop an integrated health and social care enterprise specifically aimed at helping to reduce unplanned hospital admissions for the over 75's. All of the practices future plans were part of this long term vision.

When staff were asked about the values and ethos of the practice they were not aware what these were. However, when asked to describe their and other staff approaches to delivering patient care they were able to describe the values and approach described in the statement of purpose.

Governance arrangements

Staff were clear on their roles and responsibilities and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system. All the policies and procedures we looked at, such as chaperone policy, Mental Capacity Act policy and human resources policies were up to date. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff within the practice.

We saw evidence that they used data from various sources including incidents and complaints to identify areas where improvements could be made, such as putting a procedure in place to ensure that abnormal test results should be checked twice.

The practice had identified lead roles, such as for safeguarding and infection control. In addition both the GPs and nursing staff had specific areas of specialism. These included palliative care, mental health and chronic diseases.

Some clinical audit was carried out however, there was a lack of awareness amongst the GPs of the findings of audits undertaken by their colleagues meaning that the sharing of learning and improvement from audit findings was limited.

As the premises were shared with two other practices the responsibility for identifying, recording and managing risks in these areas was with the building manager. However, the practice manager was informed of any issues. The practice manager was able to show us a checklist for potential risks and health and safety assessments which addressed a wide range of health, safety and welfare issues, such as legionnaires risk assessment.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery and described the culture as friendly, open and supportive. Staff said they were supported to deliver a good service and good standard of care and that both the GPs and practice manager were available and approachable. Staff felt confident in raising concerns or feedback.

Staff described communication as generally good; although the practice had identified that they needed to have more full practice meetings. Much communication throughout the practice was informal and ongoing, rather than through structured minuted meetings.

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

There was an active PPG, which met quarterly. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population. Patients were encouraged to participate in the Friends and Family Survey via reception and the practice website. We spoke with a member of the PPG and they told us that the practice was responsive to suggestions and worked with them to develop solutions. The practice discussed with the PPG patient survey reports and produced action plans and reviews from these, which were published on the practice website. Examples of actions included improving information displays in reception and promoting the on line appointment system.

Are services well-led?

Good

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

Staff told us they felt confident giving feedback. Staff stated they felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. Appraisals took place where staff could identify learning objectives and training needs.

The practice had completed reviews of significant events and other incidents, and shared these with staff via team meetings and discussions to ensure the practice improved outcomes for patients. However the dissemination of learning could be improved with more regular and structure practice meetings that included all clinical and administrative staff.