Thistlemoor Road Surgery

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.

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Overall summary

Thistlemoor Road Surgery provides a primary health care service for approximately 15,000 patients. At the time of our inspection, there were three partner GPs. They employed five salaried GPs. A trainee GP and a junior doctor undertaking foundation training were completing placements there. There were four nurses; 11 health care assistants (HCAs) and a team of administrators and receptionists. Health visitors and district nurses are located within the practice building and other healthcare staff hold clinics there.

We checked to see if services were safe, effective, caring, responsive and well-led. We found that Thistlemoor Road Surgery met all of these criteria. We looked at how the practice provided services for patients who were aged over 75; for patients with long-term conditions; for mothers, babies, children and young people; for patients of working age and those recently retired; for patients in vulnerable circumstances who may have poor access to primary care and for patients experiencing poor mental health. We found evidence of positive care for patients in each of these groups.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. There was evidence of a safe track record and systems to report and analyse significant events. Complaints and other events were discussed with all staff so that everyone could learn and work together to improve safety within the practice. Policies and procedures for safeguarding children and adult patients were robust and included multi-disciplinary working. Evidence provided by staff confirmed that safeguarding policies were understood and followed. The practice building and facilities were well-maintained. Clear policies for infection control and the management of medicines were followed so that patients experienced a clean environment and all medicines were safe for use. Patients we spoke with confirmed that they felt their healthcare was in safe hands.

Are services effective?

The practice was effective. Important information from NHS England, the local Clinical Commissioning Group (CCG) and area team and from the National Institute for Health and Care Excellence (NICE) was shared with staff and acted upon. All staff had training records which were up to date. Staff had access to appropriate levels of supervision. A pro-active approach to patient recall ensured that patients had the ongoing care they needed. Improvements in patient care were achieved through audit processes. The practice team demonstrated their knowledge of local cultures, local services and legal principles to provide information for their patients and to enable them to give informed consent to treatment. The practice building provided space for other services to be brought to patients 'under one roof' and promoted positive working relationships between different teams of health professionals.

Are services caring?

Thistlemoor Road Surgery is a caring practice. We found that staff at all levels had a positive approach to meeting the needs of their patients and patients confirmed that they could access the care they needed when they needed it. The organisation of reception services promoted the privacy and dignity of patients. Practice staff were compassionate. They provided care using the 'Gold Standard Framework' (GSF) for people who were approaching the end of their life. The practice team worked alongside other health care professionals to achieve the involvement of patients and positive outcomes from treatment. Healthcare assistants were key members

Summary of findings

of the practice team at Thistlemoor Medical Centre and most spoke a range of languages, including the languages used by the practice patient population. This supported health promotion and patient involvement in care.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice had a strategic approach to responding to the healthcare needs of their patient population. Staff had designed an appointments system and a range of clinics which met the needs of the population. They sought the views of their patients about services; they scored well in health targets set by the NHS and had plans in place for ongoing improvements. In particular they had designed a staffing structure which was efficient and well-liked by patients. They employed a large team of healthcare assistants and trained them to be competent in greeting and taking basic information from patients; taking blood pressure and performing other basic health checks. Some healthcare assistants had been trained to take blood samples (phlebotomy) and to run smoking cessation clinics with oversight from GPs. Healthcare assistants were recruited from the local population; they supported the wider practice team in understanding the backgrounds and cultures of patients

Are services well-led?

The practice was well-led. Thistlemoor Road Surgery is a family owned and managed medical practice. It is well-led by three GP partners and a management team of trained and committed staff. A partner GP explained to us that it had been their vision to provide excellent care for patients and a learning culture among staff. We found that this had been achieved. The high levels of motivation, commitment and enthusiasm shown by the practice team were linked to the strong leadership. We found effective systems of governance and innovative developments in the employment of healthcare assistants. Staff responsibilities were clearly defined; review and audit processes were in place to ensure that policies were followed. There were contingency plans in case of unexpected incidents and succession plans to ensure the future healthcare needs of patients would be met.

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
Older patients had a named GP and could also see another GP if they wished. Patients aged over 75 were screened for dementia when they attended the surgery. The older patients we spoke with were members of the Patient Participation Group. They were very complimentary about all aspects of the practice.

People with long-term conditions
The practice held surgeries for people with long-term conditions. They used a computer-aided recall system to ensure that people were regularly screened for changes in their healthcare needs. The practice team made regular checks that the building was suitable for disabled patients and those with limited mobility.

Mothers, babies, children and young people
Thistlemoor Road Surgery had a higher than average number of children and young people on its practice list. The practice team co-ordinated services for children with their healthcare colleagues from other NHS teams. New mothers were provided with details of initial appointments with a new baby card; community midwives used the practice building to provide baby clinics. There were robust multi-disciplinary working arrangements in place for keeping children safe from harm. Policies about working with older children and young people included guidance about obtaining their consent to treatment. Healthcare for women was monitored to ensure that they received information and checks to protect their health.

People in vulnerable circumstances who may have poor access to primary care
Many patients who attended Thistlemoor Medical Centre did not speak English. Some had come to the UK from Poland, Lithuania, Russia or Romania to work in agriculture. They often had no prior experience of a healthcare system like the NHS. Within the staff team, healthcare assistants who spoke Eastern European languages were able to communicate directly with patients and provide a translation service during clinical consultations. The practice team were alert to the needs of patients with a learning disability. NHS England expects primary care practices to develop comprehensive care plans with patients who have a learning disability to ensure their health needs are met and that they are not subject to neglect or other harm. The practice had completed health checks for most of this group of patients in the current reporting period and was using recall systems to ensure that patients were not missed.

Summary of findings

People experiencing poor mental health

We found that the GPs were knowledgeable about the range of local services for patients who presented with mental distress or mental illness. They had established positive relationships with mental health practitioners within the community and local hospitals. On the day of our inspection we saw that a referral for one patient was made promptly to the satisfaction of their carer. We found that the practice team made efforts to ensure that there were no barriers to patients seeking the help they needed. Appointments were available to support people with poor mental health at times which met their needs.

Summary of findings

What people who use the service say

Before the inspection we had left comment cards for patients to complete and post into our sealed box. We received 21 completed cards. Every response was positive with patients describing the practice as excellent and the staff as kind and helpful. Patients described the practice facilities as clean and told us how well the appointments system worked.

We spoke with 15 patients who were similarly positive. They expressed a high level of satisfaction with the services available, confirming that care was personalised; confidentiality was maintained and that people were treated in a dignified way. They said they appreciated a choice of male and female clinicians.

We saw three patients before and after their consultation with a doctor. These patients told us they were very happy with the care they received that day. One new patient, who told us they had been dissatisfied with care they had received elsewhere, said afterwards that they had been listened to by the GP at Thistlemoor Medical Centre and their anxieties had been lessened.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The GP partners had recognised that their practice building had the potential for development. They had planned what they hoped to achieve and over time they had invested in the practice building to provide a range of services for patients. They increased the number of consulting rooms so that the patient list could be increased to its current size of about 15,000. They developed a resource room where patients could access healthcare information in different languages; a multi-faith prayer room and a comfortable room for mothers to breastfeed their babies. They provided meeting rooms for their Patient Participation Group and a Carers' Group. They made surgery space for other NHS staff including health visitors, community nurses and community midwives. They invited a private healthcare enterprise to use an area of the building to provide an endoscopy service, which enabled patients to have some investigations at the surgery, instead of attending a hospital. Patients told us that the availability of a range of services 'under one roof' was convenient and time saving for them. Staff told us that sharing a building promoted positive multi-disciplinary relationships.

The practice used two soundproofed rooms to receive telephone calls into the practice. These rooms are separate from the main reception area. Privacy for patients was increased and reception staff were able to focus on the patient they were speaking with without interruption or distraction.

The practice has a large team of 11 healthcare assistants. A partner GP had observed a model of training healthcare assistants to undertake some tasks traditionally undertaken by GPs and nurses in the USA and had recognised the potential of the model to increase services for patients. The GPs developed their use of healthcare assistants at Thistlemoor Medical Centre and found that it enabled them to increase the number of patients seen by GPs during a clinic and increase the level of service provided. The healthcare assistant team includes staff from Eastern Europe, reflecting the ethnicity and languages used by the patient population. This is a further enhancement to patient services. The deployment of healthcare assistants at Thistlemoor Medical Centre was reviewed by Sheffield University in 2007 and found to be both safe and popular with patients.

This practice team had a notable positive attitude to patient care. They understood the characteristics of their patient population, including those patients who had recently arrived from countries in Eastern Europe. Their approach to all patients was to be as flexible as possible and responsive to their needs. However, underpinning this was a highly organised and efficient practice team and systems to ensure that the quality of the service remained high at all times. Both these aspects of the

Summary of findings

service reflected the values of the partner GPs and the management team. Patients recognised the quality of the practice. Every patient we spoke with and every patient who left a comment card for us gave us positive feedback about the practice. They told us they were always able to get a same day appointment, usually with a doctor of their choice. Patients who were non- English speakers conveyed to us that they were able to talk with someone who spoke their language and patients said they found staff kind, understanding and supportive.

The practice had developed a learning culture and took every opportunity to learn from patient experiences in a structured and thorough way.

Thistlemoor Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Two CQC inspectors; a GP specialist advisor and a practice management specialist advisor. We were joined by a CQC inspection evaluation advisor who observed the inspection process.

Background to Thistlemoor Road Surgery

Thistlemoor Road Surgery is sited in a residential area close to the city centre. It serves approximately 15,000 registered patients. Compared with other practices in the area, it has the highest proportion of patients under the age of 18 and the lowest proportion of patients over the age of 65. It has a more deprived population than the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area average and the England average. There is significantly higher income deprivation affecting children and older people than the CCG and England averages.

This is a family owned practice with three partner GPs and a further five salaried GPs. It is a training practice and when we inspected there was a GP registrar, undertaking specialist GP training and a junior doctor undertaking foundation level training at the practice. The practice employed four nurses at different grades plus 11 healthcare assistants and ten receptionists. There were an additional nine managerial and administrative staff. Health visitors and district nurses employed by other providers within the NHS are also based in the practice building.

Thistlemoor Road Surgery does not provide out of hours services to its patients. These are operated by another provider in Peterborough and their details are given on the practice website and in practice leaflets.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

We carried out an announced inspection of this primary medical care practice on 5 September 2014. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. As part of our inspection we spoke with 15 patients and read comment cards left for us by a further 21 patients. We spoke with over 20 members of the practice team including six doctors; two practice nurses, managers, administrators, health care assistants and receptionists. We spoke with NHS staff employed by other NHS provider organisations.

We read a range of documents produced by the practice, including policies, practice guidance, staff records, minutes of meetings and audits. We reviewed summaries of information based on statistics collected by the local Clinical Commissioning Group (CCG) and other parts of the NHS. We observed non-clinical activities throughout the day.

Detailed findings

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe patient care

Patients are protected by a strong comprehensive safety system. The information we reviewed showed that Thistlemoor Road Surgery had a safe track record. We looked at a range of policies and risk assessments which described how the practice aimed to provide safe care for patients and maintain the safety of staff. We saw that all staff were required to confirm they had read policies during their induction and as new policies were introduced. One of the GP partners told us that they monitored all aspects of patient care in regular reviews and clinical audits. We saw evidence of reviews and audits including those with a focus on safe prescribing.

We saw that all complaints were treated as significant events for investigation. This reflected the openness we observed throughout the inspection. We found that the practice had a determination to learn from patients' experiences wherever they could. We saw that complaints were investigated in a structured manner. We saw that action plans and learning followed from investigations. In respect of one complaint we looked at, we saw that an investigation had led to a change in practice protocol to ensure patient records were safely maintained.

We were told that there had never been any issues with the clinical performance of staff at the surgery and that there had never been a serious untoward incident.

One patient wrote on one of our comment cards that the surgery was a safe environment for women and girls.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at a sample of records and saw that a structured review template was used to gather and analyse information in a thorough way. Learning from each incident and an action plan was evident. During our meetings with staff, we were told that all risks, incidents and learning from incident analyses were discussed at staff meetings. An analysis of trends was reviewed annually. One recent trend was abusive and threatening behaviour by a small number of patients. The review and analysis had resulted in some changes to protect staff.

A further identified risk was people coming into the building and using the toilets inappropriately. Toilets for patients' use were now kept locked and patients requested a key. Patients told us they liked this system because it meant the toilets remained hygienic.

Safeguarding

Statistical information indicated that the practice had a significantly high number of child patients and that the overall level of income deprivation for this group was high. We spoke with one of the health visitors who confirmed that the incidence of domestic violence and child safeguarding concerns in the area was high.

We spoke with the lead partner GP for safeguarding. They showed us that the practice maintained a detailed file containing documents in relation to safeguarding children. It contained a detailed policy; clear local procedures and information in a flow chart format for staff to follow if they had concerns. We saw that these were in place for staff taking telephone calls so that they had guidance to follow if child safeguarding concerns were indicated. The practice safeguarding file also contained policies and protocols relating to abuse of adults. We saw guidance about safeguards for people who made a 'living will'.

We saw that GPs had updated their mandatory training in safeguarding every three years as required. The partner GPs had completed training at Level 3 as is best practice. In addition we were told that all staff completed safeguarding training at an appropriate level.

We observed a lunchtime clinical meeting attended by GPs, other practice staff and by one of the health visitors. We saw that the practice staff took a pro-active approach to reviewing children at risk or potential risk. We saw that there was a multi-disciplinary approach to formulating strategies to protect children. The health visitor told us that the links between domestic violence and child safeguarding were recognised and that GPs were open to working with health visitors to prevent family difficulties from escalating.

We met with a community nurse who described their role in caring for older patients who were unable to get to the surgery. They confirmed that the GPs were always receptive when they had concerns and would visit patients at home when the nurse requested a medical opinion.

Health care assistants and receptionists had been trained to act as chaperones. Most of the staff in these teams were

Are services safe?

multi-lingual, reflecting the languages used by members of the patient population. One patient explained that they felt secure having a chaperone present who spoke their own language.

We saw that patients' personal information was kept securely. There were governance arrangements in place to ensure that only staff who required access to medical records had the means to see this part of the computer system. Paper records were kept in locked storage outside the main practice area.

We were shown audits and reviews covering different areas of general practice and saw that comments made about improving patient safety were logged, reviewed and acted upon.

Monitoring safety and responding to risk

There were systems in place to ensure that patient records were stored, updated and reviewed in ways that protected patients' right to confidentiality and ensured they received the right care at the right time.

Patients told us they thought that the level of staffing was right and that staff were well-trained. They said they did not have to wait long to see a clinician and that all staff were very professional in their approach to patients.

The design of the building and the use of closed circuit cameras ensured that activity in waiting areas could be monitored. Any patient who had a medical emergency could be responded to very quickly. A comprehensive range of equipment and medicines were available for use in emergencies, including an emergency 'grab bag'. All staff knew where these were located and who they should refer to in any crisis. HCAs and receptionists told us there was always an emergency doctor who could respond when needed and that there was capacity within normal staffing levels so that staff could cover for one another if one or more staff needed to respond to an unplanned incident. This was confirmed by managers.

We saw that safety checks for the building and equipment were made at appropriate intervals and that all log books were up to date. For example, in respect of fire safety, we saw completed logs for weekly checks on fire alarms and monthly checks on emergency lighting and firefighting equipment. We saw that named fire marshals within the staff team had received accredited training and that there was a clear plan for evacuating the building in the event of fire.

Identified risks relating to the inappropriate use of the toilets in the building had been acted upon.

We saw that items which might present a risk to patients such as needles were stored securely and their use was monitored. Cleaning items were also stored in a locked cupboard.

Medicines management

We saw policies in place in respect of medication reviews and repeat prescribing. Patients we spoke with told us that the repeat prescription service worked well and they had their medicines in good time. They confirmed that the doctors reviewed their treatment and medicine needs regularly.

We saw policies relating to the management of medicines which were kept at the practice. There was evidence to show that practice staff understood how to process medicines when they were delivered and how to store them appropriately. Medical gases were securely stored. We looked at records which confirmed that checks were made regarding safe storage. Medicines kept in the building were listed with expiry dates. Stock was rotated. All the items we checked were in date. We saw that stock levels were recorded twice each day and a full stock check was made weekly.

Cleanliness and infection control

The practice maintained a safe environment for patients within the building. We looked at policies relating to infection control and checked cleaning logs to ensure that protocols were followed. We observed that all areas of the building were visibly clean. Patients told us the practice was always clean and tidy. They said that toilets were available for their use and that these were kept clean.

We spoke with the nurse who was the practice lead for infection control. They confirmed that they had updated their training in infection control in March 2014. One of the GP partners had also completed infection control training, in September 2013. We were told that all staff were required to complete an on-line training package which included learning about infection control.

The responsible nurse maintained a spreadsheet of all cleaning tasks and a list of all the items used by the cleaners. We saw that there were laminated reminders for the cleaners about areas to clean and instructions about which materials to use. Healthcare assistants were

responsible for cleaning down and disinfecting surfaces and beds after patients attended for minor surgery. We saw there was a stock of protective items like gloves and aprons.

The cleaners were not required to sign off their schedule of cleaning tasks, because we were told, English was not their first language. Instead, the cleaning routines were monitored each day through an inspection by the infection control lead nurse or the GP partner who led on infection control. They signed to confirm that cleaning tasks had been completed.

We saw that water outlets had been assessed during 2014 and that there was no evidence of legionella. There were arrangements in place to manage the collections of clinical and other waste.

Staffing and recruitment

We looked at staff employment files and saw that there was a robust system for recruiting new staff to ensure that they were suitable to work in a healthcare setting. References were followed up; applicants' hepatitis B status was reviewed and criminal records checks were completed. Staff were allowed to start work before the criminal records check was received back but only under supervision.

We spoke with two newly appointed staff. They confirmed that these checks had been made before they started working at the practice.

We spoke with one of the partners about their disciplinary policies. The doctor referred to one example of the process being used. They told us they had access to employment law support when they needed it. They described the grievance process for staff and confirmed that no staff member had raised a grievance in the previous eight years.

Dealing with Emergencies

The practice had a business continuity plan in place. The document detailed the responsibilities of the management team and identified the action staff should take in the event of a disruption in the running of the service. Information in the plan included instructions on what to do if there was a failure in the supply of domestic utility services, a fire or a change in staffing numbers. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred.

Underpinning this, we noticed there was a flexible, 'can-do' team culture within the practice that would support a rapid response.

Equipment

Records we looked at showed that contracts were in place to ensure that equipment used at the practice was regularly calibrated and checked. The schedule for maintenance was fully up to date and confirmed that the equipment was safe and suitable to be used.

We saw that a defibrillator, which is used to re-start a person's heart if it stops, was available. It was fully charged, ready for use and a spare battery was available.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

The practice actively participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local CCG led enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care in general practice.

A partner GP told us that new NHS alerts about medicines and patient safety, information from NICE and information about best practice were reviewed by one of the GP partners and the deputy practice manager. The deputy practice manager showed us that a copy of the information was kept in an 'Alerts' folder. The information and guidance was shared with the other GPs and other appropriate staff. The information was discussed at the weekly clinical meeting. We were able to track this process and we saw that at a recent meeting the re-classification of a medicine to controlled drug status in accordance with NICE guidance, was discussed.

The practice is commissioned by NHS England to take an enhanced role in monitoring and reducing unscheduled hospital admissions. When we attended a clinical meeting, GPs told us that chronic disease management, palliative care and strategies to avoid hospital admissions were discussed with the practice team and with multi-disciplinary teams. The urgent care 'dashboard' within their computer system enabled them to check when their patients were admitted to hospital.

Doctors described their systems for recalling patients who have long-term conditions for medical reviews using computer alerts and a pro-active approach to contacting patients by phone or home call.

We talked with staff about end of life care. We found that the practice adhered to the Gold Standard Framework for patients who were approaching the end of their lives. This included involving patients, their families and other healthcare professionals in advance care planning discussions and working in teams to deliver care in accordance with patients' wishes.

Management, monitoring and improving outcomes for people

Practice staff were engaged in monitoring and improving the quality of their services and the outcomes for patients.

We saw that clinical audit cycles were completed. We looked at examples of clinical audits including referral management; patient attendance at Accident and Emergency departments; minor surgery procedures and consent; prescribing of certain drugs. The outcomes of audits were used to support learning for staff and improved outcomes for patients.

There were also checks and reviews of processes to ensure these followed policy guidance or templates. We looked at checks on consent to minor surgery and reviews of the summaries which were completed by healthcare assistants using standardised templates. We saw that checks and reviews were signed off by a partner GP, a manager or a nurse, according to who held responsibility for the process.

Our data sources showed that patients at Thistlemoor Road Surgery had a statistically high incidence of irregular heartbeat. We saw that there was an audit designed to maximise appropriate care for these patients. We found evidence of two completed cycles of investigating patient need with appropriate learning and action planning to improve their treatment.

GPs told us that every patient who was a frequent attender at the practice had a specific care plan. In respect of patients who were nearing the end of their life, they used the 'Gold Standard Framework' for end of life care. This sets standards to ensure that patients have appropriate levels of care, including home visits, by a team of doctors and nurses. Patients and their families are involved and supported to express their wishes and make choices about their care for as long as possible.

The practice had policies in respect of obtaining consent from patients. A high proportion of the practice patients had come to Peterborough from Eastern Europe. The practice had recruited staff who had also come from Eastern Europe and spoke a range of languages, including Polish, Lithuanian, Romanian and Russian. When GPs were unable to be sure that patients whose first language was not English understood their treatment plans, they were often able to bring in healthcare assistants who spoke the same language at the patient. In addition, the practice used internet translation sites to produce their information leaflets in any language requested and could access other interpreting services if necessary.

The GPs we spoke with demonstrated that they understood the concept of Gillick competence and Fraser guidelines in

relation to obtaining consent and treating young patients; and the requirements of the Mental Capacity Act 2005 in relation to patients who had reduced understanding of treatment options.

Staffing

The continuing development of staff skills, competence and knowledge was seen as integral to ensuring high-quality care. We looked at six staff employment files, training records and revalidation logs. We saw evidence that all staff were appropriately qualified, trained and where appropriate, had current professional validation. Robust checks had been made on new staff to ensure they were suitable for a role in healthcare.

Training records were very comprehensive for staff at all levels. Each staff member had a training plan specific to their role that covered all their training requirements from their start date.

All GPs are subject to five yearly external revalidation by NHS England to ensure they remain competent to practise as a doctor. Within the practice, GPs were appraised annually. We looked at the log which provided details of the GPs' revalidation and appraisal dates and confirmed that they had been declared competent to practice within five years. We saw evidence that all staff had an annual appraisal and new staff had checks on their performance at regular intervals during their first year in post.

A doctor who had recently joined the practice for their first year of specialist GP training told us they had access to clinical supervision and that their induction had included a review of policies and procedures. A doctor who had joined the practice for foundation level training told us they had good support and clinical supervision and opportunities to discuss any concerns.

All new staff received an induction and regular reviews during their first year of employment. After that they were appraised annually. The staff we spoke with told us their induction was thorough and that they felt supported to learn and develop. New nurses in the practice confirmed they received supervised training from one of the GP partners before they worked independently.

Healthcare assistants played an important role in this practice. Ongoing training was encouraged, enabling those health care assistants who were interested to develop new skills to progress further. They assisted with reception duties. They provided preliminary screening for patients before they saw a GP or nurse practitioner. They often provided an interpretation service. They undertook routine checks like taking a patient's temperature and blood pressure. The practice had trained some healthcare assistants in taking blood samples (phlebotomy). This enabled the practice to offer five phlebotomy clinics during the mornings. The GPs told us that blood results could be available in the afternoon of the same day, ensuring that some patients could begin necessary treatments without delay.

We saw that each clinical skill learned and acquired by a healthcare assistant was signed off by one of the GP partners before that element of care was provided for patients. We found this to be a robust process. Healthcare assistants told us they appreciated the opportunities for development available to them. Two managers told us they had started as receptionists and had taken up opportunities for additional training to progress into their current roles.

Patients told us that they liked their preliminary discussion with a healthcare assistant before seeing the GP. Some patients said they had noticed that their input had increased the efficiency of the practice. Every patient we spoke with confirmed that they got a good service from the practice.

GPs told us that the model enabled them to provide care for more patients and to spend more time undertaking clinical tasks. They referred to a shortage of trained GPs and told us that their approach provided away of addressing this.

Nurses told us they welcomed the sharing tasks with well-trained healthcare assistants. They said they thought the approach to staffing within the practice worked well for patients.

Receptionists and healthcare assistants worked on a rotation of tasks during their working day. In some areas these tasks were inter-changeable. Staff told us they had variety in their work and enjoyed this flexible approach.

We were told that the practice building had developed to its present size over time. The layout was well-planned and all areas were well-equipped, enabling the practice to provide effective delivery of care. The building has four zones containing examination rooms and waiting areas plus a central reception. Some parts of the building were used by other health providers. For example, health visitors

Are services effective?

(for example, treatment is effective)

employed by a local health trust were based within the practice building. Another organisation provided an endoscopy clinic there, which enabled some patients to have clinical investigations locally rather than attend a hospital clinic.

On the morning of our inspection at least 60 patients were queued at the two entrances. We observed that the receptionist responsible for greeting patients at that time of the day did so in a friendly and efficient manner and helped patients to get to the area where they would be seen by a clinician. We observed that the queue was short-lived and that patients were re-directed efficiently and calmly.

Patients told us they did not experience long waiting times to see GPs or nurses. They told us they valued having a range of healthcare services 'under one roof'.

Working with other services

Thistlemoor Road Surgery does not provide an out-of-hours services for its patients. This is a service which is contracted out to another provider. The deputy practice manager told us that each morning they processed the messages from the out-of-hours service and logged all information about their patients onto a spread sheet. The messages were reviewed by one of the GPs and this was recorded for audit purposes. The spread sheet was cross-checked with the system entries made by the out-of-hours provider and the patient records were updated. This was a robust system which ensured that patient information was managed appropriately between the two services to ensure effective delivery of care.

The partner GPs had welcomed external organisations to use the practice building as a resource. Health visitors had an office base there and although their contact with families usually took place in a local children's centre, they were well-placed to be a link between patients and GPs. The health visitor we spoke with was very positive about the relationship between the service and the benefits for patients.

Community midwives held clinics within the practice building. This contributed to the patient experience of a 'one-stop shop' which some patients described to us in positive terms. We saw that links with families were effective and welcoming. When the practice received notice from maternity care units about a new birth, they completed registration administration and at the same time sent a card to the new parent along with first appointments for post-natal checks and baby immunisations.

Community nurses supported older people at home. They were not based in the practice building but were frequent visitors. One community nurse told us they used the relationships they had built up with clinical staff. This ensured that people who could not attend the surgery received home visits from the GPs when they needed them and prescriptions for their medicines.

For those patients who were approaching the end of their life, the practice provided care within the 'Gold Standard Framework' to ensure that patients received the best possible palliative care. The GPs told us they worked closely with Macmillan nurses who support people with life limiting illnesses. They held a monthly palliative care meeting with other doctors, nurses, healthcare assistants and Macmillan nurses.

In relation to patients with mental health needs doctors told us about the links they had with a variety of service providers, including a service which focused on the needs of younger adults.

Health, promotion and prevention

Staff consistently supported patients to lead healthier lives through a pro-active approach to health promotion and prevention of ill-health. Every contact with patients was used to review their health status and deliver targeted services. All new patients were offered an initial consultation with a nurse practitioner or GP. Particular care was taken to obtain information about any medicines the patient was using, as some patients brought medicines with them from their home countries. The doctors described the importance of developing the relationship with patients who had no previous knowledge of the NHS and what it could and could not offer.

We observed that health promotion information was available around the building and that this was available in English, Polish, Lithuanian and Russian and could be translated into other languages when requested. There was a particular focus on smoking cessation and we saw that health care assistants ran these clinics. Staff who ran clinics told us that patients tended to choose to attend a clinic run by a staff member who spoke the same language as they did.

Are services effective?

(for example, treatment is effective)

We saw information about domestic violence was prominently displayed in waiting areas with helpline numbers and service details. This complemented safeguarding information used by staff when responding to vulnerable adults.

We saw that staff receiving incoming telephone calls were able to review the status of patients' routine health checks including cervical smears and contraceptive reviews. They were able to offer appointments accordingly. GPs used 'opportunistic' methods to achieve a high level of these checks. For example on the morning of our inspection a GP took the opportunity to provide health prevention care when a patient attended the practice for another health issue.

GPs told us that all people aged over 75 were routinely screened for early signs of dementia when they attended the surgery. They used a template to record responses to questions and depending on the outcome could offer further tests.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were respected and empowered to be partners in their own care. The practice had sufficient space to separate the telephone reception from the main reception. Two staff answered telephone calls from two soundproofed rooms. This enabled them to speak with patients without interruption or distraction and to maintain the confidentiality of the patient. We observed a health care assistant and a receptionist receiving calls in the two rooms. Both staff members were consistent in their appropriate and helpful telephone manner. We observed that one patient who telephoned in an anxious state received a compassionate response and was provided with a same day appointment. We saw that when a patient needed to discuss a repeat prescription and this line was busy the staff member took their details and arranged a call back.

We saw that the main reception included areas where the counter height was suitable for wheelchair users. We saw that one person who attended the practice in their wheelchair was helped to the appropriate area of the building. We asked several patients about their experience at the reception and when they telephoned in. Each one commented that staff had been friendly and helpful. They confirmed what we had seen, that patients were treated with respect and empathy.

We saw that the computer screens provided clear information about which GPs had available appointments and we saw that emergency appointments were available with the designated duty GP that day. The HCA told us that the number of appointments available usually met patient demand, but if not they would refer to the duty GP and more appointments would be made available. The positive attitude of the staff promoted the dignity of the patients.

Clinical staff maintained a compassionate approach. A young carer who was concerned about their young relative told us they appreciated the urgent referral made by one of the GPs to a local service. The GPs told us that this service had a flexible approach to supporting young adults with undiagnosed mental health or substance related symptoms. The GPs said they had established positive relationships with other services to benefit patients.

We saw that clinical staff worked to the 'Gold Standard' of care for patients who were at the end of their life. They worked within a multi-disciplinary team which included Macmillan nurses to empower patients to make decisions about their care and treatment for as long as possible. They provided a range of ways to support bereaved families at the practice or through signposting to other services.

The practice building has been extended over time and patients access the main entrance through a walkway between two extensions. We saw that patients queued here before the practice opened in the morning. The area has been made into a pleasant space with plant containers. We looked at plans for work which was about to commence to build a roof over the area, so that the waiting time would be more comfortable for patients.

Involvement in decisions and consent

We observed a strong, visible, person-centred culture throughout the practice. Patients told us that the GPs and nurses provided them with clear explanations about their health and involved them in formulating treatment plans. Approximately 50% of the patient population were recent immigrants from Eastern Europe and did not speak English. In response to this, the practice had recruited staff from Poland, Romania, Lithuania and Russia to help overcome barriers to supporting this group of patients. The partner GPs had devised a training programme for these staff so that they were able to undertake translation in a clinical setting. Patients who did not speak English as a first language told us they welcomed having a healthcare assistant who would support their communication with clinical staff. GPs told us that their bi-lingual staff provided more than an interpretation service in that they gave a deeper insight into the cultural norms patients carried with them and how these impacted on treatment plans. Staff members who had themselves come from Eastern Europe told us they were proud to be able to support patients in this way and contribute to their involvement in their healthcare.

We saw that notices in the practice and leaflets about a range of conditions were available in different languages.

The GPs we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care plans and their capacity to give their own informed consent to treatment.

Are services caring?

They were knowledgeable about the Mental Capacity Act 2005 and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The GPs told us about local advocacy services and described how they helped patients get in touch with them.

They told us about involving carers in patients' treatment plans and about their support group for carers. We saw that information about this service was publicised in the building and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice responded to individual patient needs and promoted flexibility and choice in their care. We spoke with the partner GP who led on strategic planning for the practice. We saw that there was a practice development plan which covered a three-year programme of improvements including building on the quality of outcomes for patients. We saw that the practice has had high scores for services within the Quality Outcomes Framework (QOF) established by NHS to promote excellence in healthcare and managed locally by the Clinical Commissioning Group (CCG) and Local Area Team.

Last year, their score had fallen in respect of services for patients with diabetes. We saw there was a clear plan to improve outcomes for these patients.

A partner GP was involved with the CCG and met with GPs in other practices to discuss local issues for general practice. These were shared with the practice team through practice meetings and team meetings.

Staff at all levels demonstrated to us that they understood demographic factors about their patient population. In particular they told us about the challenge of delivering medical care to people who had come to live in this country from countries in Eastern Europe within the last ten years. They told us that this group of patients often had different cultural expectations of health care compared with the established community. We found that staff were flexible, helpful and eager to reduce barriers for people seeking healthcare.

The practice building had grown with the increase in patient numbers. It was well-planned and provided a calm and pleasant environment for people. Staff told us that the number of appointments available was sufficient to meet the need of patients. Receptionists and healthcare assistants worked on a rota covering different tasks. One of the managers told us that this was useful at busy times because staff were confident to cover where the need was greatest.

GPs told us that they used the 'choose and book' system when patients required further medical treatment. This enabled patients to have a choice about any hospital care they needed. They had a system for getting routine referral letters out the same day. Patients told us the practice doctors explained treatment options to them clearly. They said that communication between the practice and other parts of the NHS worked well and that they knew what to expect when their GP referred them on to other healthcare services.

The deputy practice manager explained that messages from the out-of-hours service were reviewed by a GP and that patient records were updated daily.

The practice had an active patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with six members of the PPG who told us they met twice yearly with GPs and other staff. They did not raise any areas of dissatisfaction with us and were positive about all aspects of the practice. Some long-standing members of the PPG had seen the practice develop over time; they told us that having a range of services within the practice building was very helpful and was appreciated by patients.

The practice undertook an annual patient survey and regularly involved their PPG in commenting on the quality of the services provided. They said they had been involved in drafting patient satisfaction surveys and discussing the outcomes of these. They told us that they were impressed that during their meetings with practice staff there was an open culture and the partners shared with them information about complaints and things that occasionally went wrong. They told us they recognised that the partner GPs who led the practice were always receptive to developing services for patients. They told that the current appointments system and the resource room for patients had been areas in which they had made a positive impact.

Access to the service

The practice had designed an appointments system which met the needs of their population. The practice had organised staff time so that each of the GPs provided a 'walk-in' clinic each morning between 8.30am and 10.30am. Patients told us they knew that they were likely to see a GP or nurse of their choice during this time. Patients told us how much they appreciated this.

Some patients with particular needs booked appointments during the surgery's extended opening hours between 7am and 8.30am, prior to the walk-in clinics. The GPs told us that patients who were working and patients who were experiencing distress often preferred these appointments.

Are services responsive to people's needs?

(for example, to feedback?)

GPs usually visited patients at home during the later part of the morning and saw patients by appointment during the afternoons and early evening. When we sat with staff taking reception calls during the morning we saw that patients were able to make appointments at a time which suited them, including same day appointments. Staff told us that patients could also access appointments on-line.

Practice leaflets and their website provided clear information about appointments and the range of services available plus some guidance: 'How to make the best use of the surgery'. The leaflets were available in English, Polish, Lithuanian and Russian and other languages by request. Multi-lingual staff helped patients to get the services they needed.

We spoke with 15 patients on the day of the inspection and we read 21 comment cards left for us. We received no complaints about accessing the services, seeing a GP of patients' choice or waiting times for appointments. People told us that they were always able to get appointments which suited them. Members of the PPG told us that the best thing about the practice was the morning walk-in surgery. They said they were always seen quickly and never waited more than 20 minutes.

Concerns and complaints

The practice has a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The deputy practice manager and the lead healthcare assistant were responsible for managing the complaints process, with oversight from the GP partners. We saw that information about making a complaint was available in English, Polish, Lithuanian, Latvian and Russian.

If the complaint was made verbally, the practice had a side room where the patient could be taken to speak privately about their concerns. Patients were encouraged to put their complaint in writing and there was a complaint taking template available to staff to write down details of the patient's complaint.

The deputy practice manager confirmed that a letter acknowledging a complaint was sent within 24 hours of the complaint being received. It set out the timescales for response and provided details of the advocacy service and the Parliamentary healthcare ombudsman. These details were repeated in every response letter.

All complaints were treated as significant events and recorded on a register where the complaint, outcome, recommendations and actions taken were recorded. All complaints and significant events were reviewed by the partners. The information arising from complaints was discussed with all staff at the various clinical, health care assistant, administrative and nurse meetings. We looked at the minutes of staff meetings which confirmed the processes described.

A month after the complaint had been resolved the practice sent a follow up questionnaire asking how the patient felt their complaint had been dealt with. They also followed up by telephone.

Are services well-led?

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

Our findings

Leadership and culture

The GP partners told us that their leadership of the practice had always been based upon a vision of the consistent achievement of high quality patient care. We found that they had set out clear objectives for the practice in their three-year development plan. Clear lines of accountability were in place and all staff knew who their managers were. The culture established by the GP partners reflected their vision and drove the quality of the service forward. We found that staff at all levels were actively engaged in making continuous improvements and managers trusted the staff they employed to deliver positive healthcare for patients.

The practice had displayed innovation in improving care outcomes, tackling health inequalities and obtaining best value for money. For example, we read a report from Sheffield University written in 2007 which evaluated the innovative use of healthcare assistants at the practice. The study had commented on the high levels of 'motivation, commitment and enthusiasm' demonstrated by staff and related this to the vision of the partners and their leadership in establishing a learning culture.

The practice was highly aware of risks associated with their model of working which gave prominence to the role of healthcare assistants. We saw that they had developed templates and competence checks to ensure these members of the staff team were monitored to ensure they provided a high standard of care and to mitigate against associated risks. We observed that there were comprehensive risk assessments for clinical risks and other risks associated with the practice building and staffing. We saw that all areas of risk were reviewed regularly.

There was an active focus on outcomes in primary care. When we looked at their current prescribing plan we saw that the practice had recognised where they could improve outcomes for patients with diabetes. An audit was in place to review changes made. We saw that the practice was making appropriate referrals, using pathways set out by the clinical commissioning group (CCG). They were aware their prescribing of non-steroidal anti-inflammatory medicines was high and were able to link this to patient population factors.

Thistlemoor is an established training practice for doctors wishing to be GPs and was re-approved for this in 2014. We saw thorough training records for GP trainees.

Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local CCG that the service was operating safely and effectively. There were clearly identified lead roles for areas such as medicines management, complaints and incident management, and safeguarding. The responsibilities were shared between the practice manager, the GP partners and senior nurses.

We found that the governance of each area of the practice was described in policy documents. We saw evidence that processes and procedures were working in practice. Meetings were recorded and we were able to see that decisions had been made and communicated effectively. The practice culture supported staff engagement in decisions about the service. Responsibilities were clearly defined. For example although healthcare assistants were allocated nursing tasks, the accountability for their work remained with nurses or GPs. The lines of accountability were clear and we saw that all tasks undertaken by healthcare assistants were routinely reviewed.

Review and audit was employed to manage all processes to ensure that patients experienced a safe service and good outcomes from interventions.

Systems to monitor and improve quality and improvement

The practice had a system to assess and monitor the quality of service that patients received. We saw the practice carried out a number of audits designed to assess the quality of its services. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive NHS programme designed to reward good practice. The practice was able to demonstrate that it was meeting the required QOF targets.

In addition to monitoring and reporting its performance against the national quality requirements, the provider had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG on a monthly basis. This enabled the practice and the CCG to see at a glance if any aspect of performance was below expectation and to put plans in place to improve the situation.

Are services well-led?

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

Patient experience and involvement

The partner GPs at Thistlemoor Medical Centre engaged with their PPG to gather patients' views about the quality and responsiveness of their service. PPG members told us that the practice was always receptive to their ideas for any improvements. In addition the practice sent out an annual satisfaction survey to all patients to obtain their opinions about the practice and the care they received. PPG members cited areas of improvements which had been suggested by patients and the PPG, including the patient resource room.

When practice staff analysed the results of their annual patient survey, they looked at the patient age groups represented to check that they were receiving a broad range of representation.

Staff engagement and involvement

We saw records of meetings which confirmed that staff met in their teams and as a whole staff group. We saw that all staff had opportunities to raise matters that were important to them. The use of patient toilets had been an area which healthcare assistants and receptionists had raised. This resulted in policy changes and improvements for all patients.

Learning and improvement

A founder partner described the vision they had when they started the practice to create a learning environment for staff. When we looked at training records and spoke with staff we found that this had been achieved. Members of the Patient Participation Group confirmed that the practice was always open and transparent and shared their views about learning and improving services with them.

Identification and management of risk

We saw that risk assessments were in place for all areas including breaches of health and safety, medicines management and infection control procedures. The log of risk assessments was maintained by the practice manager and specific risks were discussed with relevant staff during meetings.

We saw that there were contingency plans in place to cover staff shortages and any problems with the building. There was a clear succession plan to ensure the long-term continuation of healthcare for the patient population.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

GPs confirmed that every patient aged over 75 has a named GP in accordance with NHS guidelines. Older patients, like every other patient could choose to attend the walk in clinic and ask to see a different member of staff, if that was their wish. The practice is commissioned by NHS England to provide a Direct Enhanced Service (DES) with the aim of monitoring and reducing unscheduled hospital admissions. This is particularly relevant to the over 75 patient group.

All patients aged over 75 were screened for dementia, during routine appointments or when they presented with concerns regarding their memory.

The practice was not contracted to provide a service to local care homes. They told us however there were some people who lived in care homes who had chosen to stay registered with the practice. They provided a full service to these patients, including visits to the home when necessary.

We met with a group of six people who were over the age of 75. They were all members of the Patient Participation Group. They gave us positive feedback about the practice and were very positive about the care they each received. They confirmed that their care was regularly reviewed; that influenza vaccinations were encouraged.

When we spoke with a community nurse she told us that she worked with older people who were often housebound and isolated. She told us that the GPs at Thistlemoor were always willing to listen to her assessment of patients' needs and make home visits when appropriate. They worked in partnership with her to ensure patients had the care they needed.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

GPs and nurses told us the practice had a recall system for people with long term conditions to ensure their health needs were being met. There were regular surgeries for people with diabetes, asthma and chronic obstructive airways disease. The doctors reviewed patients' medication; nurses and healthcare assistants were involved in health checks and patient support and education. The practice team were sensitive to patients' wishes. They told us that patients with cancer for example, could if they wished have an early morning appointment before the surgery became busy during the walk-in clinics.

The practice maintained a disability checklist to ensure that disabled patients and those with limited mobility could access all areas of the practice and to ensure that that the practice complied with relevant legislation. We saw that the checklist had been reviewed in June 2014.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The statistical information we looked at confirmed that the practice's proportion of child patients was one and a half times the national average; the level of social deprivation was also high. Staff confirmed that their workload related to children was high.

All children were seen when a family registered with the practice. This enabled staff to identify children and families who might need further intervention.

The health of women was promoted. Women were encouraged to stop smoking, to attend appointments for contraceptive advice and care and routine cervical smear tests. Staff at all levels were alert to possible signs of domestic violence and there were posters about support services in the waiting areas..

A local health visitor confirmed that there were close professional relationships between the practice team and the health visiting service. Children benefitted from early clinical intervention when health visitors noted concerns.

We observed that during a clinical meeting, the GPs and a health visitor were alerted to families where issues could escalate to become safeguarding concerns. They took a strategic, multi-disciplinary approach to reducing risks to children and preventing harm. Their child safeguarding policies provided clear details about contacting the police or local authorities when there were concerns about a child experiencing harm. GPs told us that where children were subject to any intervention by the local authority, they shared information with the appropriate services and provided written reports for conferences.

There was a co-ordinated approach to engaging with families after the birth of a new baby. Mothers received information about their post-natal check and their babies' first immunization appointments with a new baby card. Community midwives held clinics within the practice. We saw that there were effective channels of communication between the different groups of professionals who worked with children and families.

Young people could access information about their own health needs and appropriate treatment. We saw that there was a specific policy relating to confidentiality and consent relating to the treatment of teenagers.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

We saw that many patients chose to come directly to the open access surgery held every morning between 8:30am and 10:30am. Patients told us they could come along early knowing that they would be seen, often by a GP or nurse of their choice. Other patients chose to telephone or book an appointment on-line. We looked at the appointment screens with a HCA and saw that patients were able to book appointments up to eight weeks in advance. The HCA told us that this was popular with working patients who could plan ahead or choose a late afternoon appointment at the end of the working day.

There was further flexibility in the appointments system offered enhanced opening hours and provided bookable appointments from 7am. These were generally used for patients needing reviews of long-term conditions.

One patient who was working told us that they appreciated that the practice offered a range of services under one roof. Time spent at the surgery was managed efficiently.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

During their clinical meeting, GPs described the challenge of providing a high quality service to patients who did not speak English and who had different cultural understandings of the scope and nature of NHS care. They gave us an example of a new patient who was using different medicines from those which the practice would prescribe. The healthcare assistants who spoke the same language as the patient enabled the staff group to understand the healthcare the patient was used to; they supported the patient to understand the changes they would need to make. The team emphasised how well this worked; they told us that basic translation would not have been enough.

We spoke with several patients for whom English was a second or third language. One person told us that they registered with the practice when they came to the UK from another country. They had had a thorough health assessment which included a careful review of their previous care in their home country and the medicines they used. They said the care that followed was excellent.

When they needed a referral to hospital their GP had made sure they understood what their options were. The health care assistant who spoke their first language checked that they had understood everything.

A GP partner told us about the services they provided for people with a learning disability or other special needs. They had patients in supported living accommodation and residential care. They provided a service to adults with a learning disability who lived with support in a local unit. Nineteen of their patients were eligible for the LD health check as set out by NHS England. They used their recall system and opportunistic contacts to engage with these patients; they said that last year 13 patients had the health check.

Staff told us that some patients with special needs preferred to come in at 8am before the surgery became busy so that their time with the GP, nurse or health care assistant was not rushed. During the consultation or review, the team used a health template to screen patients with a learning disability to check whether they were experiencing neglect or other harm. We found that the practice team had a flexible and sensitive approach to meeting the needs of vulnerable patients. They had attended training provided by local people with a learning disability to develop their awareness of the needs of this group of patients.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

During our inspection we spoke with patient and their relative before and after their consultation with a healthcare assistant and a GP. The patient was experiencing mental distress. There was concern that no help would be available to them. We learned that the GP had used their knowledge of local services and made a referral to a specialist service which the patient and their family member were comfortable with. The patient and their relative told us the GP had been supportive and encouraging. They said they felt optimistic about the referral which had been made and that they were satisfied with the outcome of the consultation.

We found that patients benefitted from the practice team having effective links with counselling and psychological services, the community mental health team, and the community psychiatric nursing team which provided gateway services and support for young adults.

Staff explained to us that some patients with mental illness chose to make use of the early bookable appointments with GPs.