South Brent Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of South Brent Health Centre in the village of South Brent on 18 November 2014. The South Brent Health Centre at Plymouth Road, South Brent, TQ10 9HT provides primary medical services to people living in South Brent and surrounding villages. The practice provides services to a diverse age group.

Our key findings were as follows:

The South Brent Health Centre operated a weekday service for over 5,100 patients in the South Brent and surrounded villages. The practice was responsible for providing primary care, which included access to the GP, minor surgery, ante and post natal care as well as other clinical services. At the time of our inspection there were three male GPs, two female GPs, two registrars, three practice nurses, two healthcare assistants, a practice manager, and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, health visitors, physiotherapists, counsellors, podiatrists and midwives.

Patients we spoke to and the comment cards we looked at confirmed that people were happy with the service and the professionalism of the GPs and nurses. The practice was clean and there were effective infection control procedures in place.

We found that staff were well supported and the practice was well led with a clear vision and objectives. Staff had a sound knowledge of safeguarding procedures for children and vulnerable adults.

Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner.

All the patients we spoke to during our inspection were very complimentary about the service and the manner in which they were cared for.

There was an open culture within the organisation and a clear complaints policy.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Medicines were stored, managed and dispensed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a service to patients. Staff received the necessary training and development for their role. There was a proactive approach to using data to analyse and improve outcomes for patients. There had been a range of clinical audits, which had resulted in improvements to patient care and treatment. There were robust recruitment procedures in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. There were named GPs for patients over 75, and the patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver quality care and treatment. Staff reported an open culture and said they could communicate with senior staff. They felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice. Patient engagement was central to the operation of the practice.

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 providing care to older people. Patients over 75 years old had a named GP to provide continuity in care. A register of carers was kept. There were safeguards in place to identify older adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care.

Pneumococcal vaccination and shingles vaccinations clinics were provided at the practice for older patients or given during routine appointments. Vaccines for older patients, who had problems getting to the practice, or those in local care homes, were administered to them in the community by the district nurse.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes, coronary heart disease, and asthma. This was to ensure each patient's condition was monitored to help manage symptoms and prevent long term problems. There were recall systems in place to ensure patients with long term conditions received appropriate monitoring and support. The practice had formed links with the local hospice and the palliative care nurses liaised closely with the staff at the practice.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Staff worked well with the midwife to provide antenatal and postnatal care. Six week postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. The GPs training in safeguarding children from abuse was at the required level three. This met best practice.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. If these appointments were not available then a telephone consultation with a GP would be booked and extended surgery hours would accommodate the patient if needed to be seen. The practice operated extended opening hours on a Saturday morning for pre bookable appointments. The practice website invited patients aged over 45 years to arrange to have a health check with a healthcare assistant if they wanted. A cervical screening service was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed monthly at team meetings and monthly at the multidisciplinary team meetings. A counsellor was available one morning a week. The practice did not provide primary care services for patients who are homeless as none are known, however, staff said they would not turn away a patient if they needed primary care and could not access it. Staff told us that there were a few patients who had a first language that was not English. Patients with interpretation requirements were known to the practice and staff knew how to access these services. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing care to people experiencing for mental health. The practice was tailored to patient individual needs and circumstances, including their physical health needs. Annual health checks were offered to patients with serious mental illnesses. Any patients who missed appointments were reviewed. There was signposting and information available to patients. The practice referred patients who needed mental health services as well as support to outside services. GPs and nurses had training in the Mental Capacity Act (MCA) 2005 and an understanding or appropriate guidance available in relation to the Act when caring for patients with dementia.

Summary of findings

What people who use the service say

We looked at patient experience feedback from the national GP survey 119 responses were received. 92% of the patients said that they could see or speak to their preferred GP and 99% of patients found it easy to get through to the surgery by telephone. The practice scored highly in comparison to other practices for patients having trust and confidence in their GP and feeling as though they had been listened too. There was very positive feedback about the way staff spoke with and supported patients. All of the feedback was positive.

We spoke with six patients during the inspection and met with two members of the patient participation group. We collected 47 completed comment cards which had been left in the reception area for patients to fill in before we visited. The feedback was positive. Patients told us their care was very good, they had been listened to, and they could access the practice easily. They told us that they found the reception staff to be helpful and caring.

They told us that the staff were always welcoming and the environment clean and tidy and that they were impressed with the care and treatment that they had received.

South Brent Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, and a practice manager specialist advisor.

Background to South Brent Health Centre

The South Brent Medical Centre provides primary medical services to people living in South Brent and the surrounding villages.

At the time of our inspection there were approximately 5,100 patients registered at the South Brent Medical Centre. There are one full time GP and four part time GP partners, three male and two female. In addition the GPs are supported by three practice nurses, two healthcare assistant, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, a specialist palliative care nurse, podiatrist and midwives.

The South Brent Medical Centre is open from 8am until 6pm Monday to Friday. A Saturday morning surgery was available for pre booked appointments only to assist patients that find it difficult to visit the GP during the week. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The Practice is also a training practice for registrars and Medical students, the GPs are all involved in GP education.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting to inspect the practice, we reviewed a range of information we hold about the service and asked other organisations, such as the local clinical commissioning group, Local Healthwatch and NHS England to share what they knew about the practice. We carried out an announced visit on 18 November 2014. During our visit we spoke with three GPs, the practice manager, a registered nurse, healthcare assistants, administrative and reception staff. We also spoke with six patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

Systems were in place for reporting and responding to incidents. All safety alerts were dealt with by the GPs, nurses and administrative team. If the alert related to equipment this would be reviewed and actioned by the practice nurse. Patients told us they felt safe when attending the practice.

The practice told us that when they received MHRA alerts (medical alerts about medicines safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. The lead GP also shared medical alert information with other clinical staff in the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw records of significant events that had occurred during 2014. Team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff. The significant events log was discussed at staff meetings to identify trends. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. All staff were aware of the system for raising issues to be considered at the meetings, and said they felt able to do so.

Reliable safety systems and processes including safeguarding

Children and adults were protected from the risk of abuse because the practice took steps to identify and prevent abuse from happening. There were systems in place to identify patients who may be at risk of abuse. A GP took the lead for safeguarding in the practice and staff knew to refer any concerns to them. The GPs held a monthly meeting to discuss vulnerable patients. A health visitor attended.

All staff had received relevant training in safeguarding. The safeguarding lead GP was trained to level three for safeguarding children. This met best practice. A training record was seen which showed this. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had chaperone policy in place and was visible in the waiting room. A chaperone is a third person of the patient's choice, who may accompany them during consultation, treatment or physical examination. Nursing staff were trained to carry out this role.

Medicines management

The GPs were responsible for prescribing medicines at the practice. There was one nurse prescriber employed. The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the prescription drop-off box at the practice, use the on-line request facility for repeat prescriptions or have their prescriptions sent electronically to a pharmacist of their choice. All prescriptions were printed and there were checks in place to ensure prescriptions were secure. Reception staff were aware of questions to ask to ensure the security of prescriptions being collected by patients.

Safe management of medicines were in place. The practice nurse was responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Staff were able to show us where medicines were stored and explain their responsibilities. Medicines were kept securely in a locked cupboard. Controlled drugs were stored in the locked cupboard and only GPs had access to these. Expiry date checks were undertaken regularly and recorded.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date evidence that nurses had received appropriate training to administer vaccines. Fridge temperatures were also checked daily to ensure medicines were stored at the correct temperatures. Records indicated acceptable temperatures were being maintained.

Cleanliness and infection control

Good

Are services safe?

The practice nurse was the lead for the prevention of infection control. There were policies and procedures in place and regular infection control and cleaning audits were undertaken. On our visit to the practice we inspected the building and looked at areas where care and treatment were delivered.

The treatment rooms used by the nurses had washable flooring and there were sinks for hand washing with a supply of hand wash and paper towels. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which staff used. All surfaces could be thoroughly cleaned and we were told by the infection control lead that this procedure was carried out after each consultation. Each of the examination beds had disposable paper covers that were changed after every use. Disposable modesty curtains were changed six monthly. Equipment used by the nurses was single use and disposed of appropriately after each patient.

The GP consultation rooms each had an examination couch with protective paper covering for preventing the spread of infection. Each had a separate hand washing sink with soap dispenser and paper towels. We were told by the nurses that the GPs were responsible for their own consultation/treatment room cleanliness. The rooms we looked at were visibly clean.

There was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company.

Equipment

Fire alarms and equipment was tested and serviced by a commercial company on an annual basis. Records demonstrated that staff had received annual training in fire safety. However fire drills and fire alarm tests were not carried out to ensure safety.

First aid kits and emergency equipment were in good order and stored appropriately where they could be reached easily in an emergency.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

The practice had systems in place to monitor the safety and effectiveness of equipment. Checks were performed on oxygen cylinders and the defibrillator. All portable appliance testing, water safety, fire safety and other equipment checks had been undertaken with appropriate certification and validation checks in place.

Staffing and recruitment

The practice had a low turnover of staff. We saw new staff were provided with an induction planner when they commenced employment. This included policies and procedures about working at the practice. Locums, when used were provided in house either by the GPs or by ex GP registrars. Training and orientation was given where appropriate.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

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

Monitoring safety and responding to risk

Monitoring and assessing of risks took place. For example, we saw a fire risk assessment for the premises. There was a control of substances hazardous to health (COSHH) risk assessment available for the storage of chemicals in the practice. We saw portable appliances were tested in line with Health and Safety Executive guidance to ensure they were safe.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were

Good

Are services safe?

checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (an adverse reaction to medicines) and hypoglycaemia (low blood sugar).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and shared the appropriate learning at their meetings.

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

The practice had palliative care registers which contained the names of patients who were at the end of their life. These patients were discussed with external services to ensure patients received the care and treatment they needed and ensured continuity of patient care. The practice had two local learning disabilities homes where patients were registered with the practice.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, adult and child protection alerts management and medicines management.

The GPs told us clinical audits were often linked to medicines management information, for example we saw an audit regarding the prescribing and monitoring of drugs used to thin the blood, to ensure that the correct dosage was being given and patients were not being admitted to hospital. The GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question, and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation (only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals with the practice manager and a GP which identified learning needs. Mandatory training was provided on-line. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example keeping up to date with travel vaccinations.

The nursing staff received their clinical appraisal from a GP at the practice. The nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. Both the practice nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease as well as the administration of vaccines.

Working with colleagues and other services

The practice worked effectively with other services. Meetings were held with the health visitor to discuss vulnerable adults and children. Once a month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Good

Are services effective?

(for example, treatment is effective)

Blood results, X-ray results, letters from the local hospital including discharge summaries and the out of hour's providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The partner GPs were responsible for seeing these documents and results and for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

Information sharing

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

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Patients' blood test results were sent electronically to the practice so that they could be actioned in a timely way.

Consent to care and treatment

All GPs had sound knowledge of the Mental Capacity Act 2005 (MCA) and its relevance to general practice. GPs told us they had access to guidance and information for the MCA. They were able to describe what steps to take if a patient was deemed to lack capacity. Patients who lacked capacity to make their needs fully known had their interests protected, for example by a family member, or a carer who supported them. We were told by patients that they were able to express their views and were involved in making decisions about their care and treatment. Verbal consent would be obtained for vaccinations and smear tests and recorded on the computerised notes. One GP we spoke with told us they obtained written consent for minor surgery procedures.

Patients told us the GP and nurses always explained what they were going to do and why.

Patients were able to discuss their treatment with the GP or nurse and told us they never felt rushed during a consultation. Patients said they were involved in the decisions about their treatment and care. Staff told us in order to ensure patients made informed decisions; they would provide written information to patients. We noted there was variety of health information in the waiting area.

Health promotion and prevention

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a healthcare assistant or with a GP if a patient was on specific medicines when they joined the practice.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

The practice provided information on mental health support services on its website and external support services such as counselling. The practice worked closely with the South Brent and District caring service, a voluntary organisation based in the village. Their aim was to improve the quality of life and promote the independence of the older, isolated and vulnerable members of the community and include befriending, transport to local activities or to health appointments, prescription collection and carers support.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. Patients with long term medical conditions were offered yearly health reviews. Patients with diabetes were offered six monthly reviews.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 47 completed cards and all were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and staff were considerate, helpful and caring. They said staff treated them with dignity and respect. Patients were complimentary about their experiences with reception staff.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow basic precautions when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Care planning and involvement in decisions about care and treatment

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

A GP told us how treatment plans were in place for patients planning for their end of life care, and that where the patient lacked capacity to make decisions, family and carers were involved with the decision making process.

Translation services were available for patients who did not have English as a first language. Notices in the reception areas informed patents this service was available. A hearing loop was available for patients that were hard of hearing. The practice provided copies of leaflets in larger print if this was required.

The design and layout of the reception area meant patient records could not be viewed by those attending the practice, and records were maintained securely and confidentially.

Patient/carer support to cope emotionally with care and treatment

The practice manager told us that translation services were available for patients who did not have English as a first language. They said it was rare that this service was required.

Patients told us that they felt well supported by reception staff. We saw older patients were provided with support by receptionists. For example, a receptionist came into the reception area to speak with an elderly patient to explain how long the wait for the appointment would be.

The practice displayed carer support services in the reception area of the practice and on the practice website. Systems were in place to identify if a patient was a carer when they called to make an appointment to enable receptionists to consider carers' potential needs when calling the practice.

The practice discussed patients who had died, in multi-disciplinary team meetings to identify and review whether their care was appropriate and whether their wishes were respected. 99% of patients who responded to the most recent GP survey said that the GPs treated them with care and concern.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw from the practice website that they published the results of their patients' satisfaction survey and responded to any issues. Patients told us that they received text messages or verbal messages on their landlines from the practice to remind them they were due to attend an appointment. Patients that would require a letter informing them of their appointments had also been identified. They told us that they were also sent a reminder text if they had forgotten to attend for an important blood test. Patients could voluntarily receive these texts if they wished to do so.

GPs had their own patient lists for patients over 75 years of age. All patients who needed to be seen urgently were offered same-day appointments. Longer appointments were available for patients if required, such as those with long term conditions. Telephone consultations enabled patients who may not need to see a GP the ability to speak with one over the phone. This was a benefit to patients who worked full time or could not attend the practice due to limited mobility. Feedback from the national patient survey suggested patients were seen quickly at the practice when they needed an appointment.

The practice offered home visits to patients who required them if requested before 10:30am. This provided older patients, mothers with young children, carers or patients in vulnerable circumstances an opportunity to see a GP when they may have difficulty attending the practice.

The practice had patient registers for learning disability and palliative care. There were regular internal as well as multidisciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as local care homes and district nurses.

There was an online repeat prescription service for patients. This enabled patients who worked full time to access their prescriptions easily. Patients could also drop in repeat prescription forms to the practice to get their medicines. Patients told us the repeat prescription service worked well at the practice. The practice communicated with pharmacies that delivered for patients who found it difficult to collect their prescriptions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) were working to recruit patients from different backgrounds and younger patients to represent the patients using the practice.

We saw no evidence of discrimination when making care and treatment decisions.

Access to the service

The Health Centre's appointment system enabled patients to see a GP or nurse the same day if they phoned the practice before 10am. There was also a telephone consultation system available for patients where they could request a call back from a GP. Patients told us they could see a GP when they needed. The practice operated extended opening hours on a Saturday morning with a GP. This benefitted patients who worked full time or those with children who needed to attend out of school and working hours.

The practice had level access for patients using wheelchairs and patients with pushchairs. Some GP consultation rooms were on the first floor and could be accessed with the use of a stair lift under supervision from staff if it was required. The practice was in the process of reconstructing the downstairs layout to provide all consultation rooms on the ground floor. A separate play area with a selection of toys was available for younger children.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

Listening and learning from concerns and complaints

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

The practice had a system in place for handling complaints and concerns. The system for raising complaints was

Good

Are services responsive to people's needs?

(for example, to feedback?)

advertised on the practice website and in the reception area. The practice manager responsible for dealing with complaints from patients. We saw records showing that four complaints had been received this year and that they were acknowledged and responded to. All were discussed in staff meetings to identify any learning outcomes and share these with staff. We saw from meeting minutes that complaints were discussed periodically to identify long term concerns or trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their aim was to be a practice where their patients saw them as being conscientious,

trustworthy and reliable. The practice also aimed to be respected by other healthcare professionals and ensure that the staff working within the practice had the skills and knowledge to provide quality care. The staff we spoke with were aware of and understood their own responsibilities with the practice's vision.

Governance arrangements

Staff were aware of their role and responsibilities for identifying, recording and managing risk with the aim of improving quality. Policies were in place available for staff to refer to. Staff were clear about procedures. Nursing and administration staff were given lead roles in areas such as infection control. They had undertaken, for example, infection control audits to monitor quality of cleanliness, hygiene and practice.

The GPs at the practice each had a lead role in areas such as safeguarding, medication, and education. Clinical audit cycles had been undertaken, for example to monitor and improve anticoagulation therapy. Regular meetings were held and we saw meeting minutes that described how the practice discussed any performance, quality and risk issues, as well as any developments that were needed.

Leadership, openness and transparency

Staff told us they felt there was an open culture at the practice. Staff were clear on their responsibilities and roles within the staff teams. There were delegated responsibilities within the management team and among the partners. Staff and members of the patient participation group (PPG) told us they felt the leadership at the practice were approachable and they felt engaged in the day to day running of the practice. One partner attended PPG meetings to support the work of the PPG and ensure the leadership were fully engaged in patient feedback.

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

We met representatives from the PPG. There was a virtual PPG with a core membership. The practice manager regularly e mailed it's members in order to receive their advice and feedback. The PPG were constantly looking for different ways to increase its numbers. The PPG was involved in assisting the practice in compiling the practice survey and analysing the results. The PPG members we spoke with were complimentary about the way the practice staff involved them in the running of the practice. They told us they felt that as a group their opinions were valued and they had a real role to play in moving the practice forward.

Staff we spoke with told us they felt engaged with practice issues. They told us they could suggest ideas for improvement or concerns at their staff meetings. Staff told us that important information was reported back promptly. All of the staff we spoke with were satisfied with their involvement at the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals included a personal development plans. Staff told us that the practice was very supportive of training.

The practice had systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Clinical team meetings were used to disseminate learning from significant events and clinical audits. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits.