Dr C M Thomson and Partners, Meadowside Medical Centre

Quality Report

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Date of inspection visit: 11 December 2014
Date of publication: 19/02/2015

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

This is the report of findings from our inspection of Dr C M Thomson and Partners, also known as Meadowside Medical Centre. Our inspection was a planned comprehensive inspection, which took place on 11 December 2014.

The service provided by Dr C M Thomson and Partners is rated as good. On inspection we found that care was safe, effective, well-led and responsive to patients' needs. All patients we were able to speak to on the day of our inspection told us that the staff at the practice were caring and treated them with dignity and respect.

Our key findings were as follows:

- The practice GPs delivered good evidenced based care and treatment, following recognised best practice. Patient safety was a priority for all clinicians and staff at the practice.
- The practice nurses delivered effective disease management clinics that met the needs of patients.
- The practice was responsive to patient feedback; the reception area was recently altered to ensure telephone conversations between staff and patients could not be overheard.
- The practice was well-led; staff and clinicians consistently reviewed appointment availability to ensure all patients' needs were met.
- Feedback from patients we spoke to on the day of our inspection told us the practice clinicians were very caring. This was also the view expressed by patients who completed Care Quality Commission comment cards.

There were also areas of practice where the provider could make improvements.

- The practice had a system in place for cascade and sharing of Medical and Healthcare Products Regulatory Agency (MHRA) alerts. However, no one person was given responsibility for leading on this, for example, in co-ordination of patient healthcare reviews and adding these alerts (when appropriate) to the agenda for practice meetings.

Summary of findings

Based on the findings of this inspection the practice is rated as good.

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 delivering safe care and treatment. The practice was able to demonstrate its ability to respond quickly to any incident, protecting the welfare and safety of patients. Where any incidents had occurred, these were investigated. Any learning from the incident was shared amongst GPs, nurses and staff.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice delivered evidenced based care and treatment to patients. A system of clinical audit and benchmarking of patient outcomes over time, confirmed to GPs that patients received the best possible outcome from their treatment. Systems in place supported nursing staff at the practice in the delivery of disease management clinics. These were run effectively ensuring those patients with an exacerbation of a long term condition had access to care and treatment quickly.

Are services caring?

Good

The practice is rated as good for delivery of caring services. All staff at the practice were aware of the importance of patient feedback. Throughout our inspection we saw patients being treated with dignity and respect. Patients told us they had trust and confidence in the clinicians and staff at the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing services that are responsive to patient needs. The availability of appointments was closely monitored by staff to ensure there were sufficient emergency appointments available. The practice had acted in response to patient feedback by making changes to the reception area so that telephone calls between staff and patients could not be overheard.

Are services well-led?

Good

The practice is rated as good for being well-led. The partners had recruited a practice manager with experience of developing services to meet changing demands. This had positive results; several staff members had been cross trained in other duties which meant the business continuity plan and resilience of the practice had been strengthened. Internal processes were reviewed to ensure the practice could meet the changing nature of primary care services.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care and treatment it delivers to older patients. The practice offered proactive, personalised care to meet the needs of the older people. Clinicians and staff worked hard at identifying problems that could contribute to patients not getting the best out of their individual care packages. For example, the practice identified that ophthalmology patients' discharge letters would usually be received some time after patient discharge. To ensure that there was contact between GP and patient on discharge from hospital, staff checked each patients discharge date by phone, and arranged a telephone consultation with each patient to ensure they received follow-up care and treatment. This contributed to the effectiveness of care plans designed to reduce unplanned admissions of older patients to hospital.

People with long term conditions

Good

The practice is rated as good for the care and treatment it delivers to people with long term conditions. We saw how GPs and nurses worked well with community nursing teams to ensure all patients with long term conditions received the support and treatment they needed. The practice had systems in place whereby district nurses could access and add to the entire patient record, held on line, which contributed to seamless patient care. For example, those patients who were housebound and required treatment or health checks to be delivered to them at home.

Families, children and young people

Good

The practice is rated as good for the care and treatment it provides to families, children and young people. A range of services that considered the needs of this population group were established at the practice. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and were recognised as individuals. The GPs and the nursing team demonstrated their awareness of consent issues when dealing with younger patients. Staff in reception roles had been given some training on spotting signs that a child or younger person should be seen immediately, for example, signs of an elevated temperature, fever, or non-blanching rash in children and younger patients.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care and treatment of working age people, those who had recently retired and students. The needs of population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care, treatment and support provided to patients in this population group. Annual health check appointments were offered for patients with learning disabilities and the practice held a register of these patients to ensure notice of appointments were sent out. The practice also kept an up to date register of all patients that were carers for a person with a long term condition or terminal illness. These patients were able to liaise with a member of staff who could help them access other support services in the community.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care and treatment if delivers to people experiencing poor mental health. The practice provided enhanced services including a dementia identification service and a diagnosis of dementia service. Any patients who presented with challenging behaviour could be referred to a psychiatrist who worked between practices within the clinical commissioning group (CCG) area. Where patients' mental health conditions prevented them from visiting the practice premises, home visits by the nursing team were made available.

Summary of findings

What people who use the service say

On the day of our inspection we talked to seven patients who were visiting the practice. All of those patients told us they were happy with the care and treatment they received from the practice GPs and nursing staff. Three CQC comment cards had been completed by patients and left for us to review. All comments were positive; patients commented that reception staff were helpful, kind and considerate.

Data reviewed before our inspection, specifically from the NHS Choices website, showed negative comments about the service. However, data from the Quality and Outcomes Framework (QOF) for 2013-14 showed the practice scored maximum points (100%) for quality and productivity and maximum points (100%) for patient experience. QOF is a performance measurement tool used by all practices on a voluntary basis and results from this are used to target areas for improvement. The practice manager told us how any complaint verbal or written would be responded to immediately, by offering a patient a face-to-face discussion with the practice manager to resolve any issues. The practice had been responsive to patient feedback on how it had been difficult to get through to the practice by phone to book an appointment. To remedy this, those patients who were calling the practice to get test results were given a separate number to call between certain times. This had resulted in a reduction of early morning telephone traffic, which had made it slightly easier for patients to get through to receptionists to book a GP appointment.

The practice had an active patient participant group (PPG). Meetings were held on a regular basis, usually bi-monthly. We met with a member of the group who told us the practice was responsive to patient feedback and that the group was valued by the practice staff. As an example, a group member was involved in the selection and interview process for the new practice manager.

A patient we spoke to on the day of our inspection told us how they had found it very easy to register with the practice; they commented that continuity of care was good and that the service from all staff was far more personal than they expected, given the size of the patient list, at approximately 8,000 patients.

Areas for improvement

Action the service SHOULD take to improve

The practice had a system in place for cascade and sharing of Medical and Healthcare Products Regulatory Agency (MHRA) alerts. However, no one person was given responsibility for leading on this, for example, in co-ordination of patient healthcare reviews and adding these alerts (when appropriate) to the agenda for practice meetings.

Dr C M Thomson and Partners, Meadowside Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP advisor and a practice manager advisor.

Background to Dr C M Thomson and Partners, Meadowside Medical Centre

Dr C M Thomson and Partners (the practice) is based in Congleton, south Cheshire and falls within one of the least deprived areas of England. The practice is made up of three partners and three salaried GPs. Access to a choice of male or female GP can be accommodated. The practice serves approximately 8,000 patients, delivering 28 GP sessions each week. Each session is made up of either a morning or afternoon of appointments; the total number of GP appointments available is approximately 342 per week. The practice has three nurses, two of which are nurse prescribers, with the third nurse currently training to be a nurse prescriber. A range of clinics are delivered by the nurses, to manage chronic illness and provide other health support services.

The practice delivers extended hours surgeries on Tuesday of each week until 8.00pm. The practice premises have been developed and improved over time to provide a large building with eight consulting rooms and two treatment rooms. All patient facilities are on the ground floor, making them accessible to wheelchair users and those with limited mobility. Car parking is available immediately outside the practice building. Support staff at the practice include the practice manager, two healthcare assistants, an audit manager, a senior secretary, a reception manager, two reception secretaries, six receptionists and a housekeeper.

The practice supports a local care home, visiting weekly to conduct a 'ward round', offering pro-active care on a structured basis. The practice hosts several external services, namely ultrasound scanning, audiology, pre-natal maternity care, dietician services, a community alcohol support team, incontinence service and cognitive behaviour therapy services.

The practice delivers services under a Primary Medical Services (PMS) contract. Out of hours services are provided by Eastern Cheshire Out of Hours service.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How 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.

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

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

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

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

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 December 2014. During our visit we spoke with a range of staff including two nurses, three GPs, three medical secretaries and the practice manager. We talked to with patients who used the service and met with a member of the patient participant group (PPG). We observed how people were being cared for and talked with carers and/or family members. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems and processes in place to protect patient safety and welfare. The practice manager had worked with all staff to identify any process areas that could impact on patient safety. One example was that of summarising and read coding of patient notes, which when delayed could result in a nurse or GP or out of hours services not having access to a patients most up to date medical history. Read codes are the standard clinical terminology system used in General Practice in the United Kingdom. Staff identified that some patient notes were waiting over a week to be added to the computer system. To address this, time was allocated and ring fenced within the working day for staff who were trained to read code and summarise patient information. As a result, any backlog of handwritten patient records was cleared.

The practice had a range of policies and procedures in place to ensure the premises were safe and well maintained. Staff were aware of health and safety checks conducted on an annual basis and that they should report any faults in equipment to the practice manager.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff were encouraged and supported to use the system. We were shown examples of how incidents were raised and recorded. We were shown how complaints were recorded and how these were analysed and dealt with in the same way as incidents, which meant any opportunities for learning from complaints was utilised. Changes made as a result of learning from incidents included the development of a warning system which would flag up to a GP or nurse any patients with the same or very similar names, to ensure that other identifiable characteristics would be checked at consultation, such as middle name and date of birth. This reduced the chances of entries being made on the incorrect patient record.

We reviewed minutes of practice meetings. From these we saw that any incidents or complaints were discussed openly and were a regular item on the meeting agenda. When we spent time talking with the nursing staff, they told us they were encouraged to highlight any concerns regarding patient care or welfare and that the practice partners had an open-door policy, making them accessible to all staff.

Reliable safety systems and processes including safeguarding

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

A partner at the practice was the designated safeguarding lead. All GPs had received safeguarding training to the required standard. GPs were able to tell us immediately, without checking records, how many patients were subject to a safeguarding plan. We were also given an example of how the practice had worked with other community services to protect the welfare of a patient with declining mental health. The example demonstrated that the practice had acted quickly to access professionals working in the community to support the patient.

The practice nurses provided a chaperone service if a patient required this and details of the service were clearly advertised in the reception area.

Medicines management

The practice had measures in place to deal with Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. These were recorded and sent as a workflow item on the computer system to all clinicians. The system in place meant that each clinician must acknowledge the item sent as being read. However, we noted that there was no one person responsible for reviewing the numbers of patients affected by any alert, and how review of those patients would be handled. The lead partner told us that in cases of alerts that affected a larger number of patients, they would take the lead and work with the CCG medicines management team, who attend the practice weekly. A recent update on guidance from National Institute for

Good

Are services safe?

Health and Care Excellence (NICE) demonstrated how the practice worked with the medicines management team to ensure that all patients who required a review of their treatment were seen in a timely manner.

We checked how the practice managed, stored and used vaccines. These were held in a dedicated medicines fridge in a treatment room. We noted that vaccinations with similar colour packaging were stored as far apart as possible within the fridge, to reduce the risk of error when selecting the vaccine to be administered. Records of temperature checks were maintained and stock controls were in place to ensure vaccines were used in date order. The practice had a cold chain policy document in place that was reviewed annually. Nurses we talked to on the day of our inspection referred to this document and told us they would use this as a reference point if they had any concerns about the safe storage of medicines.

Cleanliness and infection control

We reviewed the infection control procedures in place. We found the treatment rooms were well ordered, clean, tidy and held sufficient stocks of single use disposable items for use by nurses and doctors at the practice. We saw audits were in place to ensure that high standards of hygiene were maintained by all staff using the treatment room. Bins operated by foot pedal opening were available for disposal of waste, and were clearly labelled for clinical and general waste. Contracts were in place for the removal of clinical waste and sharps bins.

We saw monthly audits of cleaning schedules. These showed that all areas within the practice were being cleaned to the required standards. We were also able to review the Control of Substances Hazardous to Health (COSHH) register for cleaning materials used at the practice. This ensured that cleaning products used on surfaces in treatment areas were appropriate and safe for use in a clinical environment.

The practice had Legionella risk assessments in place which were updated annually. Water temperature checks were carried out monthly and recorded.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure testing cuffs.

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with daily requirements. The resilience of the practice had been further developed and improved recently; work by the practice manager and partners had been carried out to identify areas of work with single points of dependency (SPOD). These are duties or areas of work that are regularly undertaken by just one member of staff. This puts the practice at risk of being unable to deliver certain functions when that member of staff is absent from work. In such cases, staff had been trained in those areas of work and performed those duties regularly to ensure their knowledge remained current and up to date. This increased the resilience of the practice, for example if key staff members were absent for extended periods.

The health care assistant at the practice had been recruited approximately seven years ago and had been trained to perform a number of duties including blood pressure checks, some blood collection (phlebotomy) work, removal of sutures and giving out test results on the dedicated phone line at the practice for this. This had helped free up time for nurses to do further work on disease management clinics.

We saw that the practice had checks in place when using a locum GP. Details sent to the practice included the locum GPs work history, registration with the General Medical Council (GMC), photo identification and Disclosure and Barring Service (DBS) enhanced background check. Details of the locums entry on the performers list and evidence of cover from the medical defence union was also recorded.

We saw that all background checks were in place for permanent staff. All clinicians and the practice manager had undergone enhanced DBS checks, and all administrative support staff had standard DBS checks in place. When we checked staff files, we saw that

employment history was documented and references from previous employers had been taken up. Evidence of qualifications was also held on file. Each staff member had copies of two primary forms of identification, such as a drivers licence (paper and photo card) and passport. Staff had also provided proof of address by providing a copy of a bank statement or utility bill. A matrix of this information was held by the practice manager.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available for staff to read and a record was kept of staff that had completed on-line health and safety training.

The practice had made arrangements to ensure sufficient staff were available to deliver extended hours appointments. For these, patients could be seen by a GP or nurse. Consideration had been given to any lone-working and this had been risk assessed by the practice.

The practice kept registers of those patients who may be vulnerable, for example those with mental health conditions, people with learning disabilities, and patients who were also carers for a family member. Patients from these groups were offered a double appointment to ensure they had sufficient time with a GP. A register of patients with long-term health conditions was kept and regularly updated. The nurses used appointments with these patients to conduct reviews of treatment but also to ensure that vaccinations they may require were given at the same time, for example the flu vaccine or shingles vaccine.

Information on patients, for example those receiving palliative care, was regularly updated and shared with out-of-hours services.

Arrangements to deal with emergencies and major incidents

Practice staff had been trained to deal with medical emergencies, and equipment for this was kept at the practice. We looked at emergency medicines kept at the practice. These were kept in a locked cabinet and the key was accessible to staff qualified to administer emergency medicines. Medicines kept for emergencies were in date and included adrenalin, GTN spray, dispersible aspirin and penicillin suitable for use in emergency, for example, for a suspected case of childhood meningitis.

The practice had a defibrillator and staff were trained and confident on how to use this. Oxygen was also available for use and a multi-fit mask for use by the patient was stored with the oxygen.

The practice had a business continuity plan in place, which was revisited on an annual basis or more often in needed. The plan detailed measures to address most major disruptions, including power supply failure, data loss, staff shortages and gave contact names and details of other practice nearby who would lend support in a crisis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered evidence based treatment and support for patients. We saw how the nursing team carried out a detailed assessment of patients' needs. The practice staff had a flowchart to follow to ensure that care plans were completed to the required standard. Any changes to a patients care and treatment were recorded on a front cover sheet so clinicians would know to check the detail behind the changes, in the body of the care plan. As district nurses had full access to patient notes, this facilitated the sharing of information when a patient was being cared for in a home setting.

The practice used a risk stratification tool to identify more vulnerable patients who were at risk of unplanned hospital admission. Those patients had a detailed care plan in place and had access to a named GP. Nursing staff were also available to offer support if required. Copies of the care plan were available in each patients home, and had been agreed by the patient and / or their carer. Details had also been included on patients capacity to consent to treatment. This was reviewed regularly.

Management, monitoring and improving outcomes for people

The practice used Quality Outcomes Framework (QOF) data to target areas for improvement. The practice had an audit manager who used QOF data at weekly meetings to highlight areas for improvement and promote discussion on this. The practice nurses told us they benchmarked patient outcomes over time to ensure they achieved the expected results from their treatment, particularly those who had chronic, long term conditions. One nurse showed us work they had done in review of patients who had been taking medication for treatment of chronic heart disease, and whether those patients would benefit from a 'holiday' from that medication. Individual cases were discussed with the lead GP for this area of treatment and also at times, a cardiologist.

Doctors at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The GP responsible for carrying out surgical procedures also conducted clinical audits on patient outcomes and used this to target improvement and learning.

The lead practice nurse was able to show audits conducted on infection control. This audit was particularly helpful to staff in identifying areas for improvements, which had been implemented.

The lead GP partner had conducted audits on the effect of diabetes education meetings, which the practice had introduced in 2010. Results showed these had assisted in improving outcomes for those patients that attended the meetings, as compared with those who did not. The audit was re-visited in 2014, when results showed patients achieved better outcomes through education on diet and close management of their condition, than those patients who did not attended the diabetes education meetings.

Effective staffing

One particularly good example we saw which contributed to patient safety and welfare, was the work of reception staff, who had taken on some duties of the audit manager. Staff had linked this with follow-up work, for example when doing note summarizing staff would liaise with the Child Health department to establish if a child had missed any key vaccinations. If so, staff offered an appointment with the nurse as soon as possible to check the patient's suitability for those vaccinations. In another example, we saw how the recent audit on end of life care had been used to identify any weakness in the recording and storing of end of life care plans and access to these for other community clinicians. As a result, key staff were responsible for managing the Gold Standard Framework (GSF) end of life register and would update details of carers and whether a patient had expressed their wishes to be resuscitated.

Working with colleagues and other services

The practice used information from any incidents or complaints to improve systems and patient outcomes. We saw how the practice had recently reviewed systems for patient discharges from hospital, and for referral of patients to hospital consultants. As a result of this exercise, additional checks were put in place, for example a full medicines reconciliation on a patients discharge from hospital. Information on new medicines issued to a patient and the amount of medication issued had been recorded for review by the GP. To ensure that there was contact between GP and patient on discharge from hospital, staff checked each patients discharge date by phone, and arranged a telephone consultation with each patient to

ensure they received follow-up care and treatment. This contributed to the effectiveness of care plans designed to reduce unplanned admissions of more vulnerable and older patients to hospital.

The majority of hospital discharge letters were received by the practice electronically. We were told that less than 10% of letters from other sources were sent to them by post, and required scanning onto the system. Communications from out of hours services were also received electronically and this stated whether a home visit would be required the following day. The practice used the 'Choose and Book' system for referral of patients to hospital consultants; at the time of our inspection 100% of referrals were being made this way. This system had a mechanism in place that ensured relevant patient data, for example the most recent test results or x-ray results, were included in the information sent to the hospital.

Information sharing

The practice was able to demonstrate how it worked effectively with other services, sharing information to safeguard patient welfare. For example, district nurses working in the community had full access to the notes of patients on their visiting list. This enabled them to follow care plan updates and any changes to care regimes. The practice kept up to date registers of carers of patients and these people were included in any care plan review and if they requested it, could be referred to other community support services.

The practice had protocols in place for the sharing of information with out of hours services with updates on particular patients being shared electronically at the end of each working day. A designated member of staff maintained a register for those patients receiving end of life care, which ensured information on things such as a patients preferred location at end of life, for example home or hospital setting, was shared those involved in providing end of life care.

The practice staff attended meetings with the local authority learning disability team. These were used to facilitate the transfer of patients into the area, or to arrange home visits were those patients presented with challenging behaviour, and could be more at ease being seen in their home environment. Again, the sharing of this information was aimed at providing the best possible care for patients.

Consent to care and treatment

All practice staff were able to demonstrate their awareness on issues around consent to care and treatment. GPs at the practice referred to their use of the tools available through the Royal College of General Practitioners (RCGP) but also referred to instances when their clinical judgement regarding capacity had been recorded on patient notes. Nurses and GPs spoke of 'best interests' meetings, which had followed the guidance available on complying with the Mental Capacity Act 2005. GPs also referred to legislation for patients who were unable to care for themselves and who could be a danger to themselves and others, to be sectioned and placed in a care setting for their own safety although this had never been used.

Consent issues in respect of younger people were also considered and clinicians demonstrated their knowledge of Gillick competency in this area. Gillick competency tests whether children and young people have the maturity to make decisions about their care and treatment.

The practice had conducted an audit which had in part covered consent, in relation to end of life care. The audit looked at how well the practice managed and recorded information in patients' end of life care plans. One of the indicators monitored was whether patients' preferred place of treatment at end of life was achieved. For example, patients who had expressed that they did not want to be admitted to hospital at end of life, but to remain at home. The practice had worked with patients, their carers and families to ensure patients' wishes were documented, shared with any out of hours' services and respected.

The results of the audit were used to target areas for improvement in the recording of patient consent and any advance decisions patients had made on end of life care.

Health promotion and prevention

All patients who registered with the practice were offered a new patient health check. Information from the patient registration form was used to update any disease registers, for example, if a new patient suffered from asthma.

The reception area had displays of leaflets, information posters on health initiatives, and details of community support groups. Access to early health advice was available through structured clinics as well as individual appointments with nurses, if a patient wished to discuss

Good

Are services effective?

(for example, treatment is effective)

health concerns or exacerbation of their condition. The practice was advertising the availability of flu and shingles vaccinations to those patients who could be particularly vulnerable to those conditions.

The practice staff worked with the child health team to ensure that children and young people had received all necessary vaccinations. Those patients who may have missed these were contacted directly to make an appointment to see a nurse or GP. When we spoke with practice staff about this, we were told there had been a high take up of the offer of measles, mumps and rubella 'catch up' programmes, where patients who may have previously declined or missed this vaccination, could receive it.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at three CQC comment cards that patients had completed prior to the inspection and spoke with seven patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and that clinicians were extremely empathetic and compassionate.

The lead partner at the practice had introduced mandatory training for all clinicians and staff in compassion and how to express empathy and told us that all staff felt they benefit from this type of training.

Care planning and involvement in decisions about care and treatment

The patients we spoke to told us they were happy to see any GP or the nurses as they felt all were competent and knowledgeable. Some patients said that they had been able to see their preferred GP at most appointments but understood that this would not always be possible. Patients expressed that they valued continuity of care very highly. The staffing rotas we reviewed showed that sufficient GPs and other clinicians were on duty to cover all the appointments including the extended hour's service.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. GPs and nursing staff told us relatives and carers were involved helping patients who required support with making decisions. We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardian.

Patient/carer support to cope emotionally with care and treatment

Practice staff kept an up to date register of those patients that were a carer for a family member. These patients were offered longer appointments if they needed them to ensure their own health needs were met.

The practice waiting and reception area had a variety of support information available on organisations that can help following diagnosis of terminal illness, or support for patients who have experienced a bereavement recently.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided services that met the needs of patients. GPs worked to deliver approximately 346 face to face appointments each week. Nurses delivered disease management clinics that were structured but also had appointments available for patients to see them regarding particular health concerns. For example, if a diabetic patient was experiencing problems managing their condition themselves. Patients who required it were offered longer appointments, for example, those with caring responsibilities or those people with mental health problems. This demonstrated that the practice had sufficient capacity within its clinical appointments to meet individual patient needs.

There had been minimal turnover amongst support staff and clinicians, which enabled good continuity of care and accessibility to appointments with a GP of choice. A 'ward round' was carried out at a local care home on a specific day each week, by a named GP. This had resulted in proactive care to patients and had reduced the number of call-outs to the home.

The practice attended quarterly neighbourhood meetings, where representatives of three other practices met with the clinicians of Dr C M Thomson and Partners, to discuss any changes in demand for particular types of treatment or referral.

Tackling inequity and promoting equality

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms which were all located on the ground floor of the building. Staff were aware that the front doors were heavy and difficult to open, and would readily offer help if a patient required this.

We asked the practice partners about access to the service for more vulnerable groups of patients, for example patients from different ethnic backgrounds who did not speak English as a first language. We were told that the practice had not come across any patients who could not speak English, but that the practice website had the facility to convert all information displayed into any language. Staff confirmed they would seek the services of an interpreter should one be required or be requested by a patient.

Access to the service

The practice had made appointments available for patients to book on-line; at the time of our inspection 10% of the weekly appointments were available to be booked on-line. Practice staff also offered a triage system to patients who needed to see a GP immediately; in most cases, a nurse could see these patients and refer on to a GP if required. In information available to us, taken from the Patient Access Survey for 2013-14, the practice had not scored as highly as neighbouring practices, on answers to questions about the ease of access to appointments. In response to this, the practice had set up a dedicated telephone line for patients to ring to get test results and this was open at certain times in the day. This allowed more staff to answer calls first thing in the morning, and also reduced non-urgent telephone traffic during the busiest times of the day.

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 there was a designated responsible person who handled all complaints in the practice.

We reviewed complaints received by the practice within the last 12 months. We could see that these had been handled in accordance with the complaints policy and had been responded to appropriately. We noted that responses were comprehensive and met the timescales described in the complaints policy.

The practice was open and transparent with patients when and if they expressed any dissatisfaction with services. For example, minutes of Patient Participant Group (PPG) meetings were posted on the practice website for all patients to see. This meant that if patients had forwarded any complaints about services to the PPG, the answer from the partners and practice manager would be within those minutes.

We looked at how the practice had learned from any complaints. In one example we saw how details of patients referred to some consultants, had to be faxed rather than sent electronically. Prior to receiving a complaint, the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice did not have any mechanism in place to check receipt of the fax by the consultant's office. This presented two possible problems; the first was that the fax had not actually been picked up by the designated person, which posed questions on security and confidentiality of patient information. The second issue, which had led to the complaint, was that nobody had checked that the consultant had received and had sight of the faxed information. Following this, the practice manager put steps in place to ensure medical secretaries telephoned the office the fax was sent to and recorded the details of the transmission receipt in a patient's notes.

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 is rated as good for being well-led. We found there was strong leadership, with clear lines of account ability in place. Staff where clear on their role within the practice and how their everyday duties contributed to the achievement of the key objectives of the practice. The practice had a statement of their vision of the service, available for patients to refer to on the practice website. One of the points in the vision statement was that leaders should be open and approachable and constantly seek ways to improve the patient experience of care and treatment at the practice.

All staff we spoke to told us they knew who to approach if they had any concerns. Staff commented that they had enjoyed being up-skilled to increase their effectiveness in their role and said that this had increased their commitment to the practice.

Governance arrangements

The practice had systems for monitoring all aspects of the service and these were used to plan future developments and to make improvements to the service. The practice had an audit manager, who worked closely with the practice manager and GPs on aspects of governance such as complaints, risk management and targeted audits within the practice. Areas for audit were guided by data results, which highlighted areas for improvement. The systems in place ensured strong governance arrangements were in place.

The GP partners took an active leadership role for overseeing that the systems in place were consistently being used and were effective. For example there were processes in place to frequently review patient and staff satisfaction. We saw how action had been taken, when appropriate, in response to feedback from patients or staff. There was evidence of forward planning within the practice around the need to review and update policies and check the accuracy of current risk management tools.

Leadership, openness and transparency

There was a clear leadership structure in place at the practice, which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

Reception staff benefitted from having a reception manager, who dealt with 'front of house' problems quickly and effectively. We spoke with five members of support staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us that there was a good team spirit at the practice saying that their contribution to the success of the practice was valued by leaders.

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

The practice had an active patient participation group (PPG). We met one of the members of this group and they discussed how the practice valued their contribution to the operation of the service and listened to their insights into the patient experience. We saw examples of the surveys they conducted and how the findings had been used by the practice to improve the services. One example of this was the change to the layout and configuration of the reception area of the practice. Staff answering telephones had been screened off from the main front reception to prevent any conversations being overheard by patients waiting to be seen by a GP or nurse. The practice had also responded to patient feedback, resulting in changes to the way test results were given out to free up telephone lines during peak periods. We also noted that the practice website was regularly updated, acknowledging to patients any frustration they felt at peak times in the year, for example in the autumn and winter months, when getting through to the practice could be more difficult.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. They had the opportunity to feedback on how useful the induction period had been and to make suggestions on ways to improve it. They met with

Are services well-led?

Good

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

the practice manager to discuss progress and ensure they had the right skills to do their job. On-going peer support and formal appraisals were evident which included identifying learning and development needs.

Staff told us they had good access to training and the practice manager monitored staff training to ensure essential training was completed each year. We saw that a comprehensive training matrix for all staff employed in the organisation was in place. The practice had half a day protected learning time each month for training and sharing information.

Arrangements were in place to provide peer review of clinicians work. For example, the senior nurse at the practice reviewed work of the other two nurses. The work of the lead nurse was periodically reviewed by the lead GP partner. All areas of practice were audited by the audit manager, who reported any dips in performance or outcomes at practice meetings.