Bollington Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Bollington Medical Centre. The practice is registered with the Care Quality Commission (CQC) to provide primary care services. We undertook a planned, comprehensive inspection on 4 December 2014 and we spoke with patients, relatives, staff and the practice management team.

The practice was rated as **Good.**

Our key findings were as follows:

- Staff understood and met their responsibilities to raise concerns and report incidents, risks and near misses. Lessons were learned and communicated widely to support improvement. There were enough staff to keep people safe.
- Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their roles and further training needs have been identified and planned.
- Patients were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- The practice reviewed the needs of their local population, there was good access to services and they were responsive to patients' needs and wishes.
- The practice had clear leadership, staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. This included good engagement with patients.

We saw one area of outstanding practice as follows:

- The practice worked hard to ensure patient experience played an important role in improving quality service delivery. The practices Patient Participation Group were an important part of this. The group undertook regular patient surveys and had a lead role to play in the planning and opening of the new practice building. The practice communicated well with patients with regular newsletter. They had a good practice website and they engaged with patients via social media such as face book and twitter.

Summary of findings

There were areas of practice where the provider needs to make improvements.

The provider should:

- Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.

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. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety.Effective systems were in place to oversee the safety of the building and patients. Staff took action to learn from any incidents and to safeguard patients when appropriate.

Are services effective?

Good

The practice is rated as good for providing effective services. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met. Consent to treatment was obtained appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. The 27 patients who completed CQC comment cards and the ten patients we spoke with during our inspection were complimentary about the care they had received. They told us the GP and practice staff always treated them with dignity and they felt that their views were always listened to. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients, including having access to interpreter services. The practice responded appropriately to complaints about the service. Regular patient surveys were conducted and the practice took action to make suggested improvements.

Are services well-led?

Good

The practice is rated as good for being well-led. The service was well led and effectively responded to changes. Governance and risk management structures were in place. The practice had a clear set of values which were understood by staff and recorded on the practice website. The team used their clinical audit tools, clinical supervision and staff meetings to assess the quality of service being provided and how to make improvements.

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

Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns if needed. All staff received adult safeguarding training annually. They recognised the complex needs of older people and how best to treat them. The practice kept a register of all older people to help them plan for the regular review of their care and treatment. The practice nurse and healthcare assistant undertook structured annual assessments of older people, including their medicines.

All older patients were being assigned a named GP at the time of our inspection. If older patients were admitted to hospital in an unplanned way this was reviewed by the GP and if required changes would be made to their treatment plan for example a change in medications. Health promotional advice and support was given to patients and their carers if appropriate and leaflets were seen at the practice. These included signposting older patients and their carers to support services across the local community. Older patients were offered vaccines such as the flu vaccine each year.

People with long term conditions

Good

The practice had processes in place for the referral of patients with long term conditions that had a sudden deterioration in health. The GP reviewed all unplanned admissions to hospital. Registers of long term conditions were kept and annual reviews of patients were carried out, including a review of medications. If needed these patients were seen more regularly to monitor their conditions. All patients with an unplanned admission to hospital were reviewed by the GP on discharge. We saw health promotional advice, information and referral to support services for patients with long terms conditions such as diabetes.

Families, children and young people

Good

The practice had systems in place for identifying children, young people and families living in disadvantaged and vulnerable circumstances. The practice monitored children and young people with a high number of A&E attendances. The GP had written reports for safeguarding and child protection hearings as required.

The practice identified and reviewed newly pregnant women with ante and post natal referrals along with patients who experienced issues with their pregnancy. Regular meetings were held at the practice with midwives, health visitors and district nurses. If required the GP would liaise with school nurses working locally.

Summary of findings

Staff we spoke with were aware of consent best practice (Gillick competences). The GP undertook children immunisation sessions and the practice had procedures in place to follow up patients who did not attend their appointment. We saw health promotional advice, information and signposting to support organisations and services for families, children and young people, including for sexual health clinics and mental health services.

Working age people (including those recently retired and students)

Good

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations. Appointments were available prior to 9.00hrs on one day each week and the practice had extended hours on a Monday and Tuesday.

People whose circumstances may make them vulnerable

Good

Systems were in place for sharing information about patients at risk of abuse with other organisations where appropriate. The practice had a system in place for identifying patients living in vulnerable circumstances. Training for staff in children's and adult safeguarding matters had been completed. A register was kept of patients with a learning disability to help with the planning of services and reviews. All such patients were offered an annual health check. We heard of the close links with community teams supporting this patient group. We saw health promotional advice and information available for patients.

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. Clinicians routinely and appropriately referred patients to counselling and talking therapy services, as well as psychiatric provision.

Summary of findings

What people who use the service say

Patients whom we spoke with during the inspection varied in age and were from different population groups. They included older people, those with long term conditions, those of working age and mothers with babies. We spoke with 10 patients and we received 27 completed CQC comment cards. The comments made by patients were overall positive. They commented on the caring and compassionate nature of staff and that the new facilities were clean and tidy. Staff were reported to be friendly and helpful, they treated patients with dignity and respect. Patients told us that as the GPs had worked at the practice for a long time they were confident that theirs and their family's needs were met at all times. However a number of patients told us accessing an appointment was difficult along with their extended wait when at the practice.

Areas for improvement

Action the service SHOULD take to improve

Ensure doctors have available emergency drugs or have in place a risk assessment to support their decision not to have these available for use in a patient's home.

Outstanding practice

The practice worked hard to ensure patient experience played an important role in improving quality service delivery. The practices Patient Participation Group were an important part of this. The group undertook regular patient surveys and had a lead role to play in the planning and opening of the new practice building. The practice communicated well with patients with regular newsletter. They had a good practice website and they engaged with patients via social media such as face book and twitter.

Bollington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP and a specialist advisor who was a Practice Manager along with a patient Expert by Experience member.

Background to Bollington Medical Centre

Bollington Medical centre is registered with the Care Quality Commission to provide primary medical services. The practice covers a large area of Eastern Cheshire from Bollington to Adlington, Prestbury, Tytherington, Rainbow, Kerridge and Pott Shrigley. The practice has a complete primary health team consisting of doctors, practice nurses, health care assistants, reception, secretarial and administration staff and pharmacy technicians. The practice has a lead GP partner with a total of seven GPs working there.

The total practice list size for Bollington Medical Centre is 10872, of which 5406 are Male and 5466 are female. The practice is part of Eastern Cheshire Clinical Commissioning Group (CCG). The practice is situated in an area that has lower than average areas of deprivation. The practice population is made up of a higher than national average population aged between 44 and 54 years and a lower than national average of younger aged patients.

The practice is open Monday to Friday from 8.00hrs to 18.30hrs with extended opening hours on Monday until 21.00hrs for working people. The practice is closed half a day per month for training and development. Patients can book appointments in person, online or via the phone. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of medical services.

Why we carried out this inspection

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

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

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 4 December 2014.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice manager, registered manager, GP partners, practice nurses, administrative staff and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Reports from NHS England indicated the practice had a good track record for maintaining patient safety and during our inspection we found good systems to monitor this.

The practice manager and GPs discussed significant events and showed us documentation to confirm that incidents were appropriately reported. We saw how these were discussed at practice and GP partner meetings to ensure patient safety lessons were disseminated to all staff. Actions were taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided. The clinicians were confident that treatment approaches adopted followed best practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Staff were trained in incident and accident reporting. There was an accident and incident reporting policy and procedure to support staff with which they were familiar. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally. Of the events we reviewed that had occurred, we were satisfied that appropriate actions and learning had taken place. All actions were monitored at regular practice meetings and development days and we saw from the actions that had taken place all staff involved had used the information for shared learning and to make improvements.

The practice had a process for monitoring serious event analysis (SEA) and when required these were reported to the local Clinical Commissioning Group (CCG). They received alert notifications from national safety bodies and there was a process in place to cascade these to relevant staff as required.

We saw evidence to confirm that as individuals and as a team, staff were actively reflecting on their practice and looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice managers. GPs told us significant event audits were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice.

We saw how complaints made were used by the practice to learn and improve patient safety and experience. From the review of complaint investigation information, we saw that the practice ensured complainants were given full feedback and were asked for detailed information about their concerns.

Reliable safety systems and processes including safeguarding

There was a current local policy for child and adult safeguarding. This referenced the Department of Health's guidance. Staff demonstrated knowledge and understanding of safeguarding. They described what constituted abuse and what they would do if they had concerns. They had undertaken electronic learning regarding safeguarding of children and adults as part of their essential (mandatory) training modules. This training was at different levels appropriate to the various roles of staff.

The practice had a dedicated GP appointed as a lead in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. There was a chaperone policy in place. Staff were familiar with this however, the posters showing patients they could access this was not in the patient waiting room.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of

communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Medicines management

The practice had clear systems in place for the management of medicines. There was a system in place for ensuring a medication review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a quarterly basis with the local area team's medicines manager and CCG pharmacists to review prescribing trends and medication audits.

We observed effective prescribing practices in line with published guidance. Information leaflets were available to patients relating to their medicines.

Clear records were kept when any medicines were brought into the practice and administered to patients. Medicine refrigerator temperatures were checked and recorded daily and were cleaned on a monthly basis or as needed if there was a spillage. The refrigerator was adequately maintained by the manufacturer and staff were aware of the actions to take if the fridge was out of temperature range for the safe storage of medicines.

The practice had the equipment and in-date emergency medicines to treat patients in an emergency situation. We saw that emergency medicine, including medicines for anaphylactic shock, were stored safely yet were accessible. We observed that there was a system for checking the expiry dates of emergency medicines on a monthly basis or more regularly if used. We reviewed the bags available for doctors when doing home visits and found they did not routinely hold medicines and there was no risk assessment in place to support this decision.

The practice also had two pharmacy technicians whose roles were to ensure that patients received medications promptly and safely particularly for repeat prescriptions and for those patients who were discharged from hospital with a change in medications.

Cleanliness & infection control

The practice nurse was the lead for infection control. They had undertaken basic training in infection control and obtained support and guidance from the local teams as needed. There was a current infection control policy with supporting policies and guidance. The practice had completed an infection control audit in July 2014 and actions plans had been put into place to make improvements. Infection control risk assessment had been carried out throughout the building of the new premises.

The practice undertook a number of sessions for minor surgical procedures each week. The treatment room was well equipped and single use equipment such as dressing packs and surgical instruments were in place. The practice used single use equipment for invasive procedures for example, taking blood and cervical smears. Hand wash and alcohol hand sanitizer dispensers were situated in all the relevant rooms. A needle stick/inoculation injury flowchart protocol was displayed in all treatment rooms where the risk to staff of acquiring an infection from this type of injury was more prevalent. Sharps containers were stored in each treatment and consultation room. We saw these containers were stored on worktops and benches away from the floor and out of reach of children. We found that legionella testing had been carried out at the practice.

The environment was clean and tidy and equipment was well-maintained with cleaning schedules for each area. We did note that some hand wash basins in doctors room required cleaning and this was pointed out to the practice manager. We saw appropriate segregated waste disposal for clinical and non-clinical waste. Contracts were in place for waste disposal and clinical waste was stored securely. We observed equipment for example, bed trolleys, ECG machines, and dressing trolleys to be clean and tidy. The practice had a cleaning schedule to ensure the equipment remained clean and hygienic at all times. Information was provided to us following the inspection to show how the practice cleaner had undergone additional training to support them in their role.

Equipment

Good

Are services safe?

The practice had systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment. Suitable equipment which included medical and non-medical equipment, furniture, fixtures and fittings were in place. Staff confirmed they had completed training appropriate to their role in using medical devices. We saw evidence that clinical equipment was regularly maintained and cleaned.

Staffing & Recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken and completed before employment, such as references, medical and fitness checks, Staff were able to describe their recruitment process and told us that they had submitted all the required information and appropriate disclosures.

There was a system in place to record professional registration such as for the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However we did discuss with the management team our concerns that negative comments made by patients relating to not being able to make an appointment might indicate there were not enough GPs to meet the demands of the local population. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GPs oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

Monitoring safety and responding to risk

The practice had a system in place for reporting, recording and monitoring significant events. We were told that incidents were reported at regular practice meetings and minutes were shown to us to demonstrate this. Formal risk assessments for the environment and premises were in place, this included a fire risk assessment and a completed legionella test for the building.

The practice nurse and pharmacy technicians monitored medications to ensure they were always available and in date. The review of the emergency treatment bag showed appropriate equipment and drugs for emergency use. Staff confirmed they had received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of a anaphylactic shock.

The practice used electronic record systems that were protected by passwords and Smart cards on the computer system. Historic paper records were stored securely in the office area.

The practice worked with the Clinical Commissioning Group (CCG) in the locality to identify patients at risk of inappropriate A&E attendances. They monitored, analysed and implemented measures to prevent these.

Arrangements to deal with emergencies and major incidents

There was a current emergency incident procedure in place. Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system. A current business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). There was suitable emergency equipment and medicines available, checked and maintained. There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Fire alarm tests were carried out and equipment maintained by the contracted company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service was effective. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. Care and treatment was considered in line with current guidance from the National Institute for Health and Care Excellence (NICE) and other published guidelines which were available to staff on the IT system in place at the practice. This included the Mental Capacity Act and the assessment of Gillick competencies for children when gaining their consent. The GPs and practice nurse systematically used this system when assessing and treating patients.

The GPs and practice nurse we spoke with were clear about the rationale for the treatments they were prescribing and providing. They confirmed they had access to clinical guidelines on the practice intranet, for example, guidance such as the appropriate management and use of medicines. Each patient attending the practice had their needs assessed and interviews with the GP demonstrated they considered current legislation, standards and nationally recognised evidence-based guidance. We reviewed a number of patient's records in consultation with the GP and found assessments were in place and treatments were appropriate. Consistency and continuity of planned care was achieved between the day and out-of-hour's service for patients with complex and end of life care needs.

We found that staff had access to the necessary equipment and were skilled in its use and GPs arranged timely investigations as required during the patient consultation. Patients we spoke with were clear about their investigations and their treatment and they understood the results of these.

The GPs told us they were leads in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions and provide patients with regular support based on up to date information. The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. Daily informal meetings described to us as 'coffee morning meetings' were held to discuss on-going patient's needs. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. We saw from practice minutes that any updates or reviews that had taken place were openly discussed amongst staff. For example the GP lead for prescribing attends quarterly meetings with neighbouring practices to review prescribing patterns and practice and this is fed back to staff at their weekly practice meeting.

The practice showed us data from the Quality and Outcomes Framework (QOF) which is a system for the performance management and payment of GPs in the NHS. This and information provided by the local Clinical Commissioning Group showed the practice had performed overall higher than the national average consistently across the last two years. The information showed the practice's regular performance was comparable to other practices in many clinical areas and in some they achieved higher than average results. We found the practice used computerised tools to identify patients with specific or complex needs. This enabled the practice to ensure that all patients requiring an annual or more frequent review or assessment would be given an appointment and review date. Systems were in place to monitor their attendance.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. They used the Quality and Outcomes Framework (QOF) to assess their performance and undertook regular clinical audit. 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, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. Examples of audits included a number of medication audits/reviews along with audits of actual conditions such as vertigo and diabetes. These were completed audits with dates set for re auditing. An example shown to us was how they had audited the infection rates of patients who had undergone minor surgery.

Good

Are services effective?

(for example, treatment is effective)

The practice had a research team employed to undertake a number of research projects including commercial studies. We heard how they were involved in asthma and atrial defibrillation research studies amongst others. The practice had been runner up for a research award from the Primary Care Research organisation.

The team was making use of clinical audit tools, clinical and peer supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. Discussion of audits, performance indicators and quality initiatives was evident in the practice team and partner meetings. Staff told us they received feedback through discussions and at meetings. The practice had a good overarching governance plan that pulled together all audits undertaken and shared this information and learning between all the staff. The practice also participated in local benchmarking run by the Clinical Commissioning Group (CCG).

The practice had achieved and implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients supported administratively by the reception/administration team. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings and how families had been supported. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives.

Effective staffing

All doctors were on the national GP performers list and this was monitored by the local CCG. The practice rarely used locum GPs but when they did, the same checks as those made on permanent staff were also made on locums. The practice had a mix of administration and reception staff working with a number of practice nurses.

The induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and job specific induction. We saw an example of a more recent employee's induction checklist that had been completed. We found all staff had received an annual appraisal, there had been some delays this year for the practice nurses due to unplanned leave. Appraisals were used to identify staff learning and development. Nursing staff had good access for networking opportunities during which time they received peer supervision. Staff were supported to undertake continuous professional development, mandatory training and other opportunities for development in their role. Essential (mandatory) training topics were identified with relevance to the different roles within the practice. All doctors working at the practice had completed their General Medical Council (GMC) revalidation process.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or were progressing towards revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). The practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

The practice manager and principal GP had ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet patient's needs. We saw effective communication, information sharing and decision making about who might best meet the patient's needs. We saw good communications with the out of hours services with information about the patient being shared with the practice each day by 8am. This included important information for instance for patients on the end of life care pathway whose needs may have changed overnight. Information received from other agencies, for example accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was scanned onto electronic patient records in a timely manner.

Good

Are services effective?

(for example, treatment is effective)

The practice worked closely with other health care providers in the local area. The GPs and the practice manager attended various meetings for management and clinical staff involving practices across the CCG. These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and each practice was benchmarked. We saw evidence of performance monitoring with action plans developed for areas needing improvement.

We saw how closely the practice was working with other practices across the neighbourhood and the community health services. This was a new venture whereby a care coordinator role had been developed to offer and coordinate support to vulnerable patients who had recently been discharged from hospital. The aim was to ensure they get additional support in their homes to keep them out of hospital and to prevent readmission when recently discharged. The practice was able to identify this population group and refer into this service either before hospital admission or after discharge.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Information was shared in this way with hospital and other healthcare providers. We saw that all new patients were assessed and patients' records were set up. This routinely included paper and electronic records with assessments, case notes and blood test results. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed on a daily basis by doctors in the practice. We found that when patients moved between teams and services, including at referral stage, this was done in a prompt and timely way.

We found that staff had all the information they needed to deliver effective care and treatment to patients. For emergency patients, patient summary records were in place. This is an electronic record that is stored at a central location. The records can be accessed by other services to ensure patients can receive healthcare faster, for instance in an emergency situation or when the practice is closed.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for invasive implantations, a patient's written consent was obtained and documented.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available.

The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services, how to access them and how to direct patients to relevant services.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered review appointments with the nurse. They offered a health check and assessment to all new patients registering with the practice and also offered NHS Health Checks to all its patients aged 40-75. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG.

The practice had ways of identifying patients who needed additional support, and they were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability they were all offered an annual health check.

Good

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, the practices own patient surveys undertaken by the practice's Patient Participation Group. The results showed that patients were satisfied with the care and treatments provided by staff. Staff were caring and friendly and they had good knowledge and experience of the patients and their family medical histories. Patients reported that atmosphere at the practice was personal and they were satisfied with the wide range of services available locally. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey for the period 01/07/2013 to 31/03/2014 had positive results for how caring the practice was.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 27 completed cards and the majority were positive about the service experienced. Patient's comments were similar to the PPG patient survey in terms of positive comments. However a number reported to us said they felt it was hard to get an appointment when needed, telephone calls were not answered promptly and patients had long waits when they arrived for their appointment.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. However the reception area was open planned and at times the conversations between the receptionists and the patient could be overheard.

Care planning and involvement in decisions about care and treatment

During our inspection patients told us they felt involved in their care. They said they were given as much time as they needed when being seen by the nurse of doctor. We saw that patients had opportunities to discuss their health concerns and preferences, to inform their individualised care options. If needed the patients family, friends or advocate would be allowed to get involved or accompany the patient during an appointment.

Staff had good communication skills. Patients were communicated with in a way they could understand and this was appropriate and respectful. We saw that written information was provided to patients with long term conditions to help them understand their disease. We saw many patients' leaflets and health promotion information some in different languages along with posters asking patients if they required advocacy services.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with confirmed how supportive the practice had been when a close relative had died. We spoke with the GP who reported that should a family need extra support than could not be given by the practice they would be referred to local bereavement support groups.

We observed that the reception staff treated people with respect and tried to ensure conversations were conducted in a confidential manner. We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives. The practice aimed to support patients to die in their place of choice, frequently this was their home. During our inspection we were shown an email form the local consultant cancer lead saying the practice was a 'shining light' in the use of electronic patient templates to help coordinate care for patients in the last year of their life.

Good

Are services caring?

Clinical staff had various ad hoc methods of supporting bereaved patients. Some would contact them personally. The practice nurse was knowledgeable in support for bereaved patients. They were familiar with support services and knew how to direct patients to these.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients, including having access to interpreter services. We found that the practice was responsive in terms of seeking and acting upon patients views.

Patients were able to contact the practice via telephone, call at the practice, internet access was also now available for booking appointments and for ordering repeat prescriptions. Having access to online appointment booking enabled the patient population to have a 24/7 access to the practice. This system provided additional convenience for patients and enabled the practice to function more efficiently. The practice had also introduced a text messaging service to patients reminding them of their appointment.

We saw effective team work, with a mix of GP's, trainees, practice nurses and health care assistants (HCA's) all undertaking different roles safely and effectively. This meant that work previously undertaken only by GP's was now being done by others meaning patients had increased access to a primary care professional more quickly. The practice also had two pharmacy technicians whose role was to ensure that patients received medications promptly and safely particularly for repeat prescriptions and for those patients who were discharged form hospital with a change in medications.

The practice understood the different needs of the local population and acted on these when improving services. Members of the Patient Participation Group (PPG) we spoke with told us they were actively involved with reviewing the services to ensure the needs of the local population were met. These included their views and wishes for the new practice building. We heard how the practice engaged with the local community and their groups. We saw how the practice engaged with commissioners of services and other acute and community providers to ensure a co-ordinated approach to integrated care. We found effective communication and information sharing between services.

Tackling inequity and promoting equality

The practice was tackling health inequalities by providing good access to medical care and helping patients navigate a complex health system. Patients we spoke with confirmed that the appointments system was easy to use. They felt staff were supportive from the initial contact and they were satisfied with the choices available to them in terms of access to the service. Patients were given a number of access choices. This included telephone advice, face-to-face contact or a home visit if needed.

We found that staff were aware of local services (including voluntary organisations) that they could refer patients to. Patient's information sign posted patients and families to welfare and benefits advice organisations. We saw that in an effort to improve access for specific diseases the practice held nurse led clinics e.g. diabetes and we found close working relationships with the health visitors and the community nursing team.

Access to the service

Opening hours met the needs of the practice population and were clearly stated and seen on a poster in the patient waiting room. However a number of patients reported their difficulty at making an appointment and their extended wait when at the practice. We discussed this with the practice team during our visit. They told us how they knew that patients were concerned about this. Access and the availability of appointment times had been discussed and reviewed on a number of occasions. Various models had been tried to improve access, the most recent being a duty doctor who did not have any allocated appointments but was available to see or call patients each day as needed. There was good early evaluation for this but on the day of our visit patient feedback still raised concerns about access and the practice team acknowledged this needed further review.

We reviewed the appointment system and found that most appointments made with doctors and nursing staff were for a 10 min period, but longer appointment times were used for patients with more complex conditions. The practice used a duty doctor to monitor same day appointment requests thus enabling a triaging system whereby decisions were made about who was the best person to see the patient and when. The practice also arranged consultations via telephone with patients. These were pre planned and we were told were an effective way to assess and treat more patients. If a child required an appointment they were always seen on the same day. We also heard of a

Good

Are services responsive to people's needs?

(for example, to feedback?)

Clinical Commission Group (CCG) initiative where patients could be referred into a community out of hour's service if they required an urgent appointment that could not be met by the practice.

The practice took part in a patient access survey across the CCG which compared them to other practices within the area and nationally. The practice achieved nationally average results for questions relating to patients satisfaction with opening hours. They achieved below national averages for the ease of getting through on the telephone and the helpfulness of receptionists. They achieved above average results for the patient overall experience of GPs, being able to make an appointment and overall confidence in their GP.

We spent time in the patient waiting room and spoke with patients about their views and experiences. The area was modern as this was a new building, the reception area was open plan and this caused some anxiety for patients' in terms of patient confidentiality. Generally the area was large enough to meet the patient demands during our inspection. The area had reading materials such as magazines. The walls displayed patient information and patient leaflets were available.

The receptionists had a pleasant and helpful manner both in their interactions with patients attending the practice and during telephone conversations. We did observe that only one staff member attended the reception and for most of the time we were there this person was hurried and unable to give the time some patients might need. The practice communicated well with patients about opening times and the services offered. This information was available on the practice walls, the practice leaflet and on the practice website. During our visit patients told us they regularly had problems getting through to the practice on the telephone. Many patients told us that accessing an appointment at a time they needed was very difficult.

The practice had a very good website which displayed information for patients on a range of subjects including, opening times, the clinics available, general information about the practice including photographs of the GPs and the practice. The web page provided advice to people about health campaigns such as their flu campaign and how to access services. In addition, the website served as the gateway to the practice's online facilities, including appointment booking and repeat prescription services.

We saw good evidence of how practice staff worked with out-of-hours services (OOH's) and other agencies to make sure patients' needs were met when they moved between services. If an urgent appointment was needed and the practice was unable to see the patient they would be referred to the OOH's service so the patient could be seen more promptly. We saw that when needed a patient appointment with other providers such as a hospital referral would be made during the patient's consultation with the GP.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the service. Staff were knowledgeable regarding the complaints process. We saw posters advising patients how they could make a complaint. We looked at a number of complaints that had been made. We considered that the practice response to complaints was appropriate and actions had been taken to make improvements as required.

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 five year strategy and all staff were aware of this. This was described as a patient focused team approach to quality care. The lead GP told us how they aimed to deliver high quality care that was responsive to needs.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer and for some in hard copy in the offices. They had recently introduced a new IT system where most of the policies were located so on the day of the inspection some staff were unsure where they might find these. The practice held monthly practice meetings to identify and manage potential risks. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example infection control risk assessments for the new premises.

The practice used the Quality and Outcomes Framework (QOF) and local audits and reviews to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Local benchmarking arrangements were in place with neighbouring GP practices during which time they reviewed performance and shared best practice. There was regular review of practice with clinical audit and research systems in place. We looked at a selection of these and found good evidence for how this fitted into the overarching quality monitoring and governance systems in place.

We found practice staff were clear about their responsibilities. Staff were clear about who was responsible for decision making and there was a transparent culture within the service. We also found records with information showing the skills and fitness of people working at the practice. Team meetings were taking place and formal minutes of these were seen.

We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Leadership, openness and transparency

The management model in place was supportive of staff. All of the staff we spoke with told us they felt well supported by the management team and they enjoyed working at the practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. The practice had a strong team who worked together in the best interest of the patient. All staff were aware of the practice Whistleblowing Policy and they were sufficiently confident to use this should the need arise.

Examples of various practice meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from significant events. Regular monthly team meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had. We saw how staff views were sought at this time and changes were made for example a change to the duty doctor's processes and systems when the practice identified for them that these required improvement. We also saw how these meetings were used to share information about new developments such as a new mental health assessment tool the practice was considering using. At these time doctors discussed individual patient case studies to ensure all staff had the opportunity to learn and develop their care and treatment through reflective practice.

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

The practice recognised the importance of gaining the views of patients, carers and the public to build on and improve services. There was an active Patient Participation Group (PPG) and during the meeting we met with eight of their members. We heard of good and committed engagement with this group, they all gave positive comments for how supportive practice staff were and they gave examples for how the practice had listened and acted

Are services well-led?

Good

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

on these suggestions. We saw that for the development of the new practice building the PPG had taken a leading role and were very active on the many organised practice open days.

The practice communicates with patients and the public via social media online at Facebook and Twitter. Regular news and updates were made to these websites including flu campaigns, requests for patient feedback and the results of patient surveys and also copies of the practice annual reports and practice strategy.

We looked at complaints and found that the practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the event. We were shown minutes of a recent meeting during which time the complaints audit had been discussed. Actions were discussed to show how the practice could improve patient dis satisfaction with the reception staff.

The practice undertook regular patients' surveys and the PPG were actively involved in this. Questions were asked of patients to gain their views for the practice, access to appointments, medications, their views about the new reception and practice areas amongst others. The results of these surveys were discussed in some detail by the PPG and at staff meetings. We saw also that patients could leave comments in the reception area.

Management lead through learning and improvement

Staff had access to a programme of induction and training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff were supervised until they were able to work independently but written records of this were not kept. Annual appraisals were undertaken for all staff.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice manager maintained a training log for all staff ensuring they kept up to date as required.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff at meetings. This included an annual review of all incidents to identify themes and trends. The results of the incident analysis was discussed regularly at staff development days and we saw evidence that learning and improvements had been made when such incidents had occurred.