Neston Surgery

Quality Report

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

Summary of findings

Contents

Summary of findings

Overall summary

Neston Surgery provides medical services to approximately 8,600 patients registered at the practice in Neston, Merseyside.

The practice is registered with the Care Quality Commission to deliver the regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury.

We had left Care Quality Commission (CQC) comment cards before our inspection, for patients to express their views. We found 30 cards had been completed, the majority of which carried positive comments about the service.

GPs and practice nurses had systems in place to ensure that patients with on-going health conditions, who required close monitoring over time, received treatment that met their needs. Patients who were required to have regular blood tests were able to use the phlebotomy service at the practice.

The practice supported frail and elderly patients in two local nursing homes. Clinicians work was focussed on minimising any unplanned admissions of these patients to hospital.

We saw examples of how clinicians at the practice worked with other professionals and services to deliver the best possible outcomes for patients. For example, in cases of patients receiving palliative care.

We were able to speak to parents and carers of children who were patients of the practice. They told us they never experienced a problem getting appointments to see a GP.

Each GP took the lead in care for a particular population group. There was no lead GP with responsibility for patients who may be vulnerable due to their circumstances, for example, homeless patients or patients from travelling communities, as this was not a population group that was prevalent in the area. However there was a GP lead for patients with any learning disabilities and for those patients who experienced poor mental health. These patient groups were called for regular health checks on an annual basis which protected their physical health.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that services to patients were safe. Areas such as infection control, health and safety in the workplace, analysis of any incidents and events and other policies and procedures required some updating and review. Although any serious clinical incidents were thoroughly reviewed by GPs and clinicians, complaints from patients and the cause for complaint were not always addressed. At the time of our inspection, work to update policies and procedures had begun. A nurse appointed as the lead for infection control at the practice was working with the Clinical Commissioning Group (CCG) to introduce best practice measures for infection control. We looked at the management of medicines that required cold storage such as vaccines. Policy documents we saw referred to national guidance but there was no written procedure for surgery staff to follow, particularly for the handling of any returned or unused vaccines from district nurses at the end of the day. This lack of clear instructions for staff to follow in this regard, could present a risk of unusable vaccines being returned to stock.

Are services effective?

The service to patients was effective overall but could be improved in some areas. For example, there was a very high level of failure to attend phlebotomy appointments by patients (blood taking appointments.) Action had only been taken very recently to address this. Routine medicine reviews which could be undertaken by a nurse impacted considerably on availability of GP appointments. This was an area that GP partners were aware required attention.

Are services caring?

Patients we talked to told us the service they received was very caring, that GPs were highly compassionate and that they were always treated with dignity and respect. Our observations on the day were that reception and administrative staff were professional and treated patients with courtesy and respect. Information we looked at before our inspection also showed that positive comments about clinical care from nurses and GPs at the practice, were better than average for a practice of this size. This meant that the sample of patients we spoke with during the day, mirrored the answers given by larger patient view samples.

Summary of findings

Are services responsive to people's needs?

Overall we found the practice was responsive to patients' needs. On average 121 GP appointments were available each day for booking by patients. Our GP advisor told us this would be sufficient to meet the needs of a patient register of 8,600 people.

The practice always responded to patient complaints. However, we found that action taken to address the cause of the complaint and the learning from this was not always applied.

Are services well-led?

Clinical services were well led by the lead GP partner. Patients commented positively about their treatment from the practice GPs and were happy with the service. A new practice manager was working on development and introduction of performance reviews and annual appraisal for all administrative and support staff. These were to be introduced between June and August of 2014.

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

This population group was well supported by staff at the practice. We found that services were well led, caring and responsive to people's needs.

The practice had a GP who took the lead on dementia care and there were two practice GPs that supported local nursing homes. The partners visited each home for two hours each week to manage chronic disease and provide early interventions on other health matters. This was done in a focussed way to reduce the possibilities of hospital admissions.

In a practice booklet, available in the reception area and given to new patients on registration, it was highlighted that patients aged 75 and over would be seen by a member of the practice team for an annual check-up. If a patient could not attend the surgery, the clinician would be able to do this in a house call.

Older patients we spoke with valued the range of services offered by the practice, including the phlebotomy service and services delivered to them by practice nurses.

People with long-term conditions

As the patient register had increased in number, so had the demand for support for patients with long term conditions and chronic diseases. The practice had conducted some evaluation work to see how they could best meet this growing need. The partners decided that the practice should invest further in the training of the existing three nurses, to be able to treat a number of other conditions. As an example, nurses were trained in cytology and international normalisation ratio (INR) testing, which is the testing of bloods for managing dosage of the drug warfarin. This meant that all patients could continue to be served by the practice, rather than be sent to outpatients clinics at local hospitals.

Mothers, babies, children and young people

The services provided by the practice met the needs of this population group and the skills of the GP partners reflected this. This enabled services to be responsive, caring, safe and effective. Childhood vaccinations were delivered by the practice and the lead GP partner had a specific interest in childhood health surveillance, supported by two other partners. The lead partner showed us how

the practice worked with Health Visitors to deliver the Healthy Child Programme. This was a national initiative aimed at, for example, increased focus to reduce childhood obesity, improved nutrition and ensure better compliance with immunisation programmes.

One of the GP partners was female and had specialist interest in women's health matters. There were also three female salaried GPs working at the practice which ensured that female patients could be seen by a female GP if required, due to personal preference, cultural or religious reasons. The practice also had a well-advertised chaperone service and signs in the waiting areas expressed that patients could ask for this at any time.

The working-age population and those recently retired

Data we reviewed before our inspection showed that patients from this population group had commented that ease of access to appointments was difficult when phoning the practice. We were able to speak with two patients from this age group on the day of our inspection who told us this was still the case. However, both patients told us the service they received from their GP was very good.

We found a programme of routine vaccinations were available to patients deemed to be at risk in this population group, or patients who were from key occupations. For example, vaccination against flu or shingles. There were also clinics run for weight management, smoking cessation, family planning and contraception.

We saw evidence of nurses conducting clinical audits with GPs on patients who may be at risk due to the length of time they had been on a contraceptive medication. We also saw how recent Medicines and Healthcare Products Review Agency (MHRA) alerts had been responded to by nursing staff, in their review of patients on contraception pills who may also use herbal remedies, which could reduce the efficacy of their medication.

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

We were told that in the geographical area that the practice covered, there were no traveller sites or homeless people.

The practice did have a lead GP and nurse for the support of patients with learning disabilities and the practice kept an up to date register of these patients. This enabled the practice to request patients who experienced learning disabilities to attend the surgery for a full annual check-up of their physical health and well-being. The allocation of a specific GP and nurse for this population group allowed continuity of care and treatment for a population group that may suffer if they are not familiar with the people who provide

their care and support. In this respect we found the practice had taken steps to respond to the particular needs of this group of patients. In the information we reviewed before our inspection, we found there were no complaints from the carers, support workers or advocates of patients with learning disabilities, which suggested that the way in which services were delivered to this population group were effective.

People experiencing poor mental health

The practice had two GP partners who took the lead on treating patients who experienced poor mental health or any mental health conditions such as dementia. A patient we spoke with in the waiting area, who fell within this population group, was kind enough to share their experiences of the practice with us. They spoke very highly of the care and compassion which the GPs and all staff had showed them when they had experienced problems related to their mental health. They confirmed that they were afforded continuity of care by seeing the same GP on each visit. The also expressed how important this had been to their recovery and how staff always found ways to offer consultation appointments to achieve this.

Summary of findings

What people who use the service say

We reviewed patient surveys and other data about the service, before the date of our inspection. We found the practice had received a number of positive comments from patients who used the service. These included reference to the quality of care they had received and that care and treatment was caring and compassionate.

We reviewed 30 Care Quality Commission (CQC) comment cards that patients had completed and posted into a box for our review during inspection. The majority of the comments were favourable, with only two negative comments made regarding the tannoy system and how patients found announcements made unclear, and how background music added to their inability to hear tannoy announcements.

The Patient Participation Group (PPG) were very active in collecting the views of patients and sharing these with the practice managers and partners. They told us they were working on a new patient survey which would focus on communication with patients and how this could be improved. The PPG had also played a part in collating examples of when patient care in the community had fallen short. This was not due to GPs or associated staff, but due to postcode boundaries. This had resulted in patients discharged from one hospital, requiring after care, support and community services that were provided by another hospital. The PPG had worked with the practice partners and a member of the CCG to address this matter, which contributed to patient concerns around discharge from hospital and after care such as physiotherapy.

Areas for improvement

Action the service COULD take to improve

- Systems in place for regular annual checks of some equipment, needed to be more rigorous. As an example, portable appliance testing of electrical items for use by staff was not routinely organised.
- Work had been done to update the infection control policy and staff training, but staff could not tell us where spillage kits were kept in the practice and their knowledge in the use of these was incomplete.
- Records and evidence of fire safety drill for all staff were not kept.
- The contents of the first aid box were out of date.
- There were no clear instructions in place for the handling of any returned or unused vaccines from district nurses at the end of the day, for example flu vaccines. The lack of clear instructions for staff could present a risk of unusable vaccines being returned to stock.
- The practice could have better systems in place to learn from complaints. When we reviewed complaints we found steps or positive actions to prevent those circumstances arising again were limited.

Neston Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. They were accompanied by a GP advisor, a second CQC inspector and a practice manager

Background to Neston Surgery

Neston surgery is based in Wirral, Cheshire. Information shared with us by West Cheshire Clinical Commissioning Group (CCG) showed patient numbers as being around 7,486 patients. However, due to changes at a neighbouring surgery, the patient numbers had risen to 8,600 at the time of our inspection. All services were delivered from the one site. Neston Surgery was a teaching practice which could accommodate up to three registrars. The practice also supports fourth year medical students, on placement from Liverpool University. The practice was run by five partners, the senior partner being Dr Tahir Awan, who was also the Registered Manager of the service.

The premises were purpose built and were owned by the GP partners. The building was made up of six GP consulting rooms and two large treatment rooms. There was an additional consulting room for use by trainee GP registrars. The practice had a contract in place for phlebotomy services to be delivered at the practice, enabling people to have blood taken on the premises rather than travel to Arrowe Park Hospital for this service.

Out of hours services for the practice was provided by Wirral Community NHS Trust, based at Arrowe Park Hospital.

We saw examples of how clinicians at the practice worked with other professionals and services to deliver the best possible outcomes for patients, for example, in cases of patients receiving palliative care. Patients we spoke with commented particularly on how caring and compassionate GPs and staff of the practice were.

Why we carried out this inspection

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

Our inspection was planned and we gave advance notice of the date we would visit the practice. In the two week period running up to the date of inspection, we reviewed copies of documents sent to us by the practice and records such as patient surveys, minutes of staff meetings and records of any complaints received by the practice. We also requested a breakdown of numbers of patients in each population group. This helped us to focus on how these population groups were served by the practice and how services were provided for those groups of people.

The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 2 June 2014, between 8.30am and 6.00pm. During our visit we spoke with a range of staff including the practice manager that was due to retire, and the manager who would be taking over this role. We also spoke with two reception and administrative staff. We spoke with three of the practice partner GPs and the one member of nursing staff who was the lead for infection control. We spent time with four patients who used the service, asking them for their views.

Are services safe?

Summary of findings

We found that services to patients were safe. Areas such as infection control, health and safety in the workplace, analysis of any incidents and events and other policies and procedures required some updating and review. Although any serious clinical incidents were thoroughly reviewed by GPs and clinicians, complaints from patients and the cause for complaint were not always addressed. At the time of our inspection, work to update policies and procedures had begun. A nurse appointed as the lead for infection control at the practice was working with the Clinical Commissioning Group (CCG) to introduce best practice measures for infection control. We looked at the management of medicines that required cold storage such as vaccines. Policy documents we saw referred to national guidance but there was no written procedure for surgery staff to follow, particularly for the handling of any returned or unused vaccines from district nurses at the end of the day. This lack of clear instructions for staff to follow in this regard, could present a risk of unusable vaccines being returned to stock.

Our findings

Safe patient care

The practice had a good track record on patient safety. The practice was able to demonstrate a system of reporting and recording incidents. These were openly discussed and lessons learned were shared with all staff. There was a strong system of clinical audit which we were able to review with the lead partner of the practice. One example we reviewed showed the reassessment of patients on a particular medicine, which would require them to have liver and renal function testing conducted on a regular basis. We saw how this audit was re-visited, in a follow up audit cycle. We saw that compliance of patients with the need for renal and liver function tests had risen from 71% to 83%. This demonstrated that the system of audit in place was effective and that the conducting of follow up audit would yield results which would help measure indicators of patient and medicines safety.

The practice had a medicines manager who liaised regularly with the lead GP for prescribing at the practice. We saw that any alerts issued by Medicines and Healthcare Products Regulatory Agency (MHRA) were picked up quickly, and patients medications were reviewed in line with recommendations made. This protected patients' well-being and ensured they achieved the best possible outcome from their medications.

Learning from incidents

We were able to review documentation which recorded any serious clinical event or incident. This confirmed that circumstances surrounding the event were discussed and analysed by the GP partners and lessons learnt were applied.

We found waiting times in reception had been an issue which had triggered some complaints and incidents. The practice had always responded to patient complaints. However, we found that action taken to address the cause of the complaint and the learning from this was not always applied by administrative and support staff. The new practice manager confirmed they were looking at all the practice procedures with a view to updating and improving these.

Safeguarding

We found all clinicians and support staff had received safeguarding training to the appropriate level. We reviewed

systems in place to identify safeguarded children and vulnerable adults to all members of the clinical practice and other out of hours providers. We could see that alerts were in place to bring this to the attention of clinicians who provided their care. The practice had met its responsibilities in the attendance of any safeguarding meetings or boards and where they were unable to attend, they had submitted a full report to the safeguarding board. A named GP was the safeguarding lead at the practice and was also able to deliver training on this subject to staff. This was further supported by some training from an external provider and updates from the Clinical Commissioning Group (CCG).

Safeguarding was a regular agenda item for the weekly clinical meeting. Updates were provided by health visitors, district nurses and GPs involved in the care of any child or vulnerable adult that was the subject of a safeguarding concern. Systems at the practice supported the 'Task force around family' (TAFF). This meant that any person having involvement with the family of a safeguarded child or vulnerable adult could call a mini case conference to discuss concerns.

Monitoring safety and responding to risk

Levels of competency of all clinicians were checked, through a system of peer review. This ensured that clinicians performance was consistent over time. We saw that work performed by healthcare assistants and nursing staff was reviewed by the practice partners.

Weekly clinical meetings were held, which GPs, practice nurses, health visitors and district nurses attended. Medicine safety alerts were discussed and levels of risk to patients on those medicines. Arrangements were made for patients to attend the surgery to discuss alternative treatments if necessary.

Any clinical incidents or serious events were discussed at the meetings. If learning had come from these, it was shared and documented to reduce the possibility of similar incidents arising in future.

We could see from minutes of clinical meetings held, that GPs regularly reviewed the treatment of patients who had presented at the surgery with acute problems. Time was also given to discuss results of other initiatives and the success of these, for example of falls prevention and risk profiling of those patients. Follow-up action points were made for each GP, who would arrange to see the patient again. This demonstrated how the practice managed the safe treatment of patients and responded to any increase in risk, to prevent patient harm.

Staffing levels were sufficient to meet the administrative support functions required by the practice. The skill mix and specialisms of the GPs and practice nurses were sufficient to meet the needs of the patient register.

Medicines management

Our GP advisor reviewed the medicines alerts recently issued by MHRA and found that the practice lead prescriber and medicines manager had shared these with staff and GPs had reviewed patient treatments accordingly.

One of the partners had carried out an exercise to see what each GP carried in their bag as emergency drugs. Considerations included the medical conditions likely to be met, the medicines the GP was confident in using, the storage requirements, shelf-life and costs of such treatments, the extent of ambulance paramedic cover and the proximity of the nearest hospital. This represented good practice in the management of medicines carried in GPs work bags.

We looked at the management of medicines that required cold storage such as vaccines. We found that these were stored safely, that fridges used for their storage were regularly temperature checked and that stock was rotated and checked to ensure vaccines were safe to use. To manage the safe transportation and storage of vaccines there must be suitable arrangements in place including a cold chain policy document that staff can refer to. Policy documents we saw referred to national guidance but there was no written procedure for surgery staff to follow, particularly for the handling of any returned or unused vaccines from district nurses at the end of the day. This lack of clear instructions for staff to follow in this regard, could present a risk of unusable vaccines being returned to stock.

A practice nurse showed us how controlled drugs (medicines liable to misuse) were ordered, stored, managed and issued to clinicians working at the practice. Appropriate arrangements were in place for ordering, receiving and supplying these medicines and records were adequately maintained. A suitable storage cupboard was used to store controlled drugs but access to this cupboard was not appropriately managed because access to the key

Are services safe?

was not restricted to designated people in the practice so there was a risk these medicines might be mishandled or misused. Following our inspection, the new practice manager rang us to advise that access to the keys for the store of control drugs had been made more secure and was limited to designated people in the practice.

Our GP advisor reviewed repeat prescribing and found that there were systems in place to ensure this was done safely.

Cleanliness and infection control

At the time of our inspection we noted the practice premises were clean, tidy and maintained to a good standard. We were told that cleaning was carried out by an external contractor. We asked to see records relating to cleaning audits; we found there were no cleaning audits in place. The person who was taking over as practice manager told us that work had already started, identifying checks that were required and keeping records of these. For example toys were available for children, in the waiting area of the practice, but no arrangements were in were in place to check the toys had been cleaned and that suitable cleaning agents were used on these.

A nurse at the practice had recently been appointed as the lead for infection control. They had attended quarterly meetings with the local area infection control team and were taking guidance from them on the implementation of training for staff, hand hygiene audits and a policy for infection control at the practice. A visit from the CCG lead for infection control had been organised and this would be used by the nurse in charge of infection control at the practice, to test new systems put in place.

Staffing and recruitment

When we reviewed staff records, we found all staff has been appropriately reference checked and those with patient contact had the required background security checks in place. Any person having contact with children or vulnerable adults must undergo an enhanced background check. This check is carried out through the Disclosure and Barring Service to ensure their suitability to work with children and vulnerable adults. We saw evidence of the induction process for new staff and that staff were well supported through their probationary period. The practice partners were supported by three salaried GPs. As a training practice, a GP registrar would be on placement at the practice for six to twelve months of the year to gain more experience in general practice.

Dealing with Emergencies

The practice had a business continuity plan which detailed several scenarios and how these would be addressed, for example loss of electrical supply. Consideration had been given to roles of staff in each scenario. A section within the practice business continuity plan detailed procedures that would be followed in the event of evacuation of the practice building.

Equipment

We looked at arrangements in place for the regular service and maintenance of equipment used on a daily basis, such as weighing scales and blood pressure monitors. We found records that showed these were all checked annually and all instruments had been tested and calibrated by an approved contractor. This ensured that readings given from this equipment would be accurate.

Computers and display screens were safety checked and that staff ergonomic desk and equipment assessments had been conducted. We found that other equipment around the building had not been safety tested, for example, small portable electrical appliances that should be tested annually for safety. (PAT testing). The practice manager confirmed that this testing had not been carried out, but arrangements would be made to address this.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service to patients was effective overall but could be improved in some areas. For example, there was a very high level of failure to attend phlebotomy appointments by patients (blood taking appointments.) Action had only been taken very recently to address this. Routine medicine reviews which could be undertaken by a nurse impacted considerably on availability of GP appointments. This was an area that GP partners were aware required attention.

Our findings

Promoting best practice

We looked at how the clinicians followed guidance and recognised best practice in the treatment of patients. To do this, we looked at how the practice managed and delivered end of life care. The lead GP partner demonstrated how patients were listed on a register and marked using a traffic light system. The care delivered was in line with the gold standard framework for end of life care. This is a nationally recognised standard that affords patients compassion and dignity within their last days of life, with adequate pain management. The traffic light system communicated to practitioners – nurses, GP's and any out of hours services – what stage of palliative care a patient was at. For example, a patient with end stage chronic disease, who had been recently started on palliative care, would be marked as green. A patient who had moved toward end of life care was marked as red. We saw that clear communication was in place between all services that the patient would possibly access, such as Macmillan nurses, district nursing teams and locum GP's who provided out of hours services. Patients wishes had been recorded and shared with other clinicians. Patient records demonstrated that the Mental Capacity Act was applied and followed.

The partners of the practice conducted several quality and safety audits to ensure that best practice guidelines were followed. We saw an example of audit of GP notes that had been conducted. This revealed variances of between 55% and 85% in adherence to the expected standard for consultation notes. Results were fed back to the clinicians and plans were in place to audit again to check improvements.

Management, monitoring and improving outcomes for people

Two of the GP partners provided GP support to two local care and nursing homes. There had been focus on work at the home, in minimising the need for patients to be admitted to hospital from the homes. This could be due to chronic illness or deterioration in a patient's health. In cases were a patient had not responded to oral antibiotics, there was the opportunity for them to be treated by the hospital at home service. This included the administration of intravenous antibiotics, which previously would have required a stay in hospital. The service provided had recently been audited. Results showed it was successful in

reducing hospital admissions of patients from the homes. This was a particularly significant result as elderly patients particularly those with dementia, are better suited to treatment in familiar settings such as their home environment.

Regular clinical meetings were held on Friday of each week and attended by all GPs, the practice nurses, practice manager and wherever possible, district nurses and health visitors. We reviewed the minutes of several of these meetings. We noted there were regular agenda items, such as discussion of specific patients when management of their condition was challenging, new learning and National Institute for Health and Care Excellence (NICE) or other guideline updates, review of any serious or untoward incidents, Medicines and Healthcare Products Review Agency (MHRA) safety alerts and any safeguarding matters. Minutes of the meetings were circulated afterwards to ensure that any person absent could be updated on matters discussed. The minutes were also marked with the name of any person with lead responsibility on any actions necessary, for example, updates to support staff on any safeguarding matters or feedback following any investigation into an accident or serious incident.

We saw how the practice managed the delivery of flu vaccinations, and how clinics were organised in a way that minimised impact on normal, daily patient appointments. As a result of this, 25% of the patient register received the flu vaccine (approximately 2,150 patients). Over 50% of those who received the vaccine did so through attendance at a specially organised Saturday clinic (approximately 1,075 patients). This represented a positive outcome as the impact on normal weekly patient appointments was reduced.

Staffing

The partners at the practice had systems in place to provide peer review and support, continuous professional development and appraisal. The personal development plans of GPs that we reviewed were very detailed and had been regularly reviewed to monitor progress over time. The practice was a teaching practice, with two of the partners being involved in the teaching of doctors who wished to go into general practice. There were a further two partners involved in the support of medical students on placement form Liverpool University. The partners all took part in the appraisal process and the lead partner was an appraiser who had already been revalidated. All GPs must be revalidated to enable them to remain on the performers list. A GP must be on the performers list to deliver patient services on the NHS.

The person appointed to take over as practice manager had organised appraisals and performance review for all administrative and support staff. These were scheduled to take place in the three month period from June to the end of August 2014 so that specific staff training and development, beyond that provided by mandatory training, could be identified, recorded and organised.

Working with other services

We saw from the maintenance of the palliative care register that clinicians and staff worked hard to ensure patients benefited from effective, joined up care. Patients who were discharged from hospital received a telephone call from a GP to check on their condition and to discuss any follow up treatment and appointments required. The practice worked closely with other health professionals for example by inclusion of health visitors and district nurses at weekly clinical meetings held at the practice. This aided communication between clinicians, for example, when checking any new parents who may have failed to attend a clinic for baby vaccinations.

We were made aware of instances where patients had been discharged from hospital only to find that aftercare services such as physiotherapy had not been organised, due to their address falling within a geographical area that came under the jurisdiction of another service provider. Whilst this was nothing to do with the GP practice, it was easy to see how this could create extra work for GPs who felt bound to help patients in any way they could. The Patient Participant Group (PPG) had given seven examples to the local Clinical Commissioning Group (CCG) of patients who had not received the follow up services they required following discharge from hospital. We were told that the matter was being dealt with by a named contact within the CCG and instances such as those described to us will now be prevented from happening again.

The practice used the services of two providers of out of hours care. Wirral Community NHS Trust, based at Arrowe Park Hospital covered out of hours services during evenings and weekends. An extended hours service, providing patient appointments between the hours of 6.30pm and 8.00pm, was available at Ellesmere Port. This service also provided cover when GPs were on training days. The use of

Are services effective?

(for example, treatment is effective)

two services for out of hours services did present challenges in terms of clear communications. The practice utilised the 'special notes' section to communicate any patient critical information – for example if a patient was allergic to penicillin, or had advance directives in place in relation to end of life care. Details of any out of hours care delivered was sent to the practice by the provider of the care, by fax each morning, before 8.00am.

Health, promotion and prevention

We noted the practice had several posters displayed in relation to contraception services available. There were also a number of leaflets available in the main reception area. The practice offered Chlamydia checks as an enhanced service for 15-24 year olds. A poster promoting this was displayed in the patient toilets.

All newly registered patients were required to complete a health questionnaire, which detailed any chronic illnesses, diseases or on-going health conditions which required close monitoring over time, for example diabetes or asthma. Patients were then offered a health check with a practice nurse. Patients over the age of 75 were offered annual health checks which could be carried out at the practice. If a patient from this population group could not attend the surgery, a home visit would be arranged.

Are services caring?

Summary of findings

Patients we talked to told us the service they received was very caring, that GPs were highly compassionate and that they were always treated with dignity and respect. Our observations on the day were that reception and administrative staff were professional and treated patients with courtesy and respect. Information we looked at before our inspection also showed that positive comments about clinical care from nurses and GPs at the practice, were better than average for a practice of this size. This meant that the sample of patients we spoke with during the day, mirrored the answers given by larger patient view samples.

Our findings

Respect, dignity, compassion and empathy

The service delivered by all clinicians at the practice was compassionate and caring. We noted that all reception staff were courteous, kind and considerate when dealing with patients in the reception areas. Comment cards we had left for patients to complete before the day of the inspection had been returned. The majority of positive comments made were on the caring nature of the staff and clinicians at the practice.

The layout of the reception area meant patients conversations could be overheard by other patients waiting to see reception staff. We asked how people's privacy was protected when making enquiries at reception. The practice manager explained that staff could offer a patient the option to speak with them at a side window, which was screened and meant conversations, could not be overheard. Patients we spoke with on the day of our inspection told us they were aware of this facility and had used it in the past. Patients told us staff were aware of any privacy issues and were always sensitive when speaking with patients in the reception area.

We saw posters in the reception area advertising the availability of a chaperone service, which was provided by practice nurses. Patients we spoke with on the day of our inspection were aware of this service and said they would request a chaperone if they wanted one. We also saw that there were arrangements in place for any patient wishing to see a same sex GP, if they wished to do so due to cultural or religious reasons.

Involvement in decisions and consent

All clinicians we spoke with on the day of our inspection confirmed the training they had received and updates to this, on the issue of consent, patients capacity to give consent and the Mental Capacity Act 2005. The Act provides a framework to empower and protect patients who may lack capacity to make some decisions for themselves. The practice policy on consent was up to date and described how consent should be gained from patients before examination or treatment. The policy used examples of how information must be given to patients to enable them to make informed decisions about their care and treatment, for example, in the treatment of chronic, on-going health conditions.

Are services caring?

We looked at systems in place to add patients to the palliative care register. Our GP advisor was able to confirm that any advance decisions by patients who received end of life care was recorded in a place that could be accessed by any out of hours service GP. This meant that patients wishes had been recorded and because they were shared appropriately, they would be respected.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall we found the practice was responsive to patients' needs. On average 121 GP appointments were available each day for booking by patients. Our GP advisor told us this would be sufficient to meet the needs of a patient register of 8,600 people.

The practice always responded to patient complaints. However, we found that action taken to address the cause of the complaint and the learning from this was not always applied.

Our findings

Responding to and meeting people's needs

The practice worked hard to meet the needs of patients with multiple health conditions, particularly those patients who received palliative care. Systems were in place to support patients living with chronic diseases through to malignant stages of disease and to end of life care. The practice worked with other clinicians to ensure that care delivered responded to patients' needs and acknowledged their wishes. For example, by having patients care plans or specific requests, shared with out of hours doctors who may attend a patient being cared for at home.

The practice was able to demonstrate how it met the needs of patients who wished to be seen by a same sex GP, for religious or cultural reasons. The make-up of the medical team was well balanced in this respect. We also saw how the practice facilities met the requirements of the Equality Act; all areas were accessible to patients with mobility issues and doorways were sufficiently wide enough to allow wheelchair user access.

We were able to confirm that all GPs had a good understanding of the Mental Capacity Act and were able to demonstrate how they assessed a patients capacity to make decisions about their care and treatment.

Access to the service

Patient access to services was good for some population groups. The working age population group did experience difficulty in securing appointments with a GP. The practice had three incoming telephone lines, which at peak times could all be busy and cause frustration to patients waiting to get through to the surgery. To address this, some patients had taken to queuing outside the surgery at 8.00am in readiness for surgery opening time. People with work or caring responsibilities may not be able to do this.

To address the issue the practice had focussed on training reception staff to ensure patients were booked to see the most appropriate clinician, to ease pressure on GP appointments. For example, if a patient could be seen by a nurse, this appointment would be offered first. However we found this system did not work particularly well. A recent audit by one of the GP partners showed that in February 2014, 86 out of 100 appointments for patients requiring a prescription review for contraception were

Are services responsive to people's needs?

(for example, to feedback?)

conducted by a GP rather than a practice nurse. This suggested that screening of patient calls by reception staff had not resolved problems experienced by the working age population group, in accessing GP appointments.

For those patients who had telephoned the practice when all GP appointments for the day had been taken, reception staff would ask patients for information to complete a triage form. This would be reviewed by a GP and if necessary the GP could call the patient or offer an appointment at the end of surgery hours. Further work was required to make access to appointments with a GP, easier for those from the working age population group.

Concerns and complaints

We asked the practice for a copy of their complaint policy. The document advised patients to make their complaint to the Practice Manager. If a patient required their complaint to be dealt with by a GP, they were to inform the Practice Manager of this. The document did not set out a clear process to show how a complaint would be handled. There was no indication of how long a patient would wait for a formal response to their complaint.

The document we reviewed gave patients the details of NHS England, where patients could take any complaint they had about GP services.

Complaints we looked at showed that all complaints were responded to. In written replies to patients, we saw that circumstances which had caused the complaint to arise were explained to the complainant at length. For example, in the case of a person waiting a long time to be seen by a nurse, the staff absences were explained. However, measures to prevent such circumstances arising in the future were not put in place. We discussed one particular example of this. A patient had arrived at the practice in plenty of time before their appointment. They went into the consultation 36 minutes after it was due to start. The appointment over ran by seven minutes. This meant the next patient to be seen by that particular GP, actually started their appointment time 40 minutes later than they had expected to. This was something that patients told us they were frustrated by; even though they were happy with the service given by GPs, information on any delays to appointment times were not communicated to them whilst they were sitting in the waiting area. This was also contrary to the commitment given in the Patient Charter, set out in a booklet given to patients when they registered with the practice.

Whilst the practice responded to peoples complaints offering apologies, it was not pro-active in implementing steps to prevent similar complaints from arising again.

Are services well-led?

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

Summary of findings

Clinical services were well led by the lead GP partner. Patients commented positively about their treatment from the practice GPs and were happy with the service.

A new practice manager was working on development and introduction of performance reviews and annual appraisal for all administrative and support staff. These were to be introduced between June and August of 2014.

Our findings

Leadership and culture

There was good leadership evident from the practice partners and from the senior partner to all clinical staff. We found examples of how quality of treatment was reviewed to ensure high standards of patient care, for example, in audits of GPs notes and recording in patient electronic records. There were clear lines of accountability within the practice, with each partner GP holding responsibility for particular areas of practice, for example mental health, minor surgery or child health matters.

Succession planning was in place to accommodate the impending retirement of the practice manager. A new practice manager had been appointed and was working to ensure a smooth handover of responsibilities. Staff we spoke with during our inspection told us they felt valued and were well supported in their work.

Governance arrangements

The practice partners had defined areas of responsibility for particular aspects of the service, for example prescribing and responding to medicines safety alerts. This information was shared at clinical meetings and minutes were kept of these. Regular meetings with community professionals such as district nurses were held to discuss patients, any risk to their recovery and whether any review of treatment was needed.

We saw analysis the partners had conducted on benchmarking of practice performance. This demonstrated that the partners considered the outcomes for their patients, alongside those of GP practices of similar size, to identify areas for improvement. This was also discussed at CCG area meetings that partners attended.

A nurse had recently been appointed as the lead for infection control at the practice and was working with the infection control lead of the clinical commissioning group to develop a new, more robust infection control policy for the practice, with defined responsibilities for each nurse and treatment areas. This represented an improvement as the previous policy did not prompt regular audits on the cleaning of the surgery by outside contractors.

Systems to monitor and improve quality and improvement

The practice had systems in place for clinicians to measure quality and improvement in patient care. We saw examples

Are services well-led?

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

of how serious event analysis was used to see if patient care or a treatment could be different following learning from events. This included review of antibiotic prescribing which may have been averted, or training of staff in reception areas on how health conditions can affect patients behaviours.

Some analysis of data had been used to reduce the number of patients who failed to attend phlebotomy appointments. This produced greater availability of appointments to patients and also had a cost impact.

The practice lead partner demonstrated how they used a primary care web tool to examine the level one and two triggers for the practice. Triggers are indicators or alerts, against particular patient groups that require attention, to bring the level of patient contact and intervention up to that expected for a practice of this size. For example, we could see level one and two triggers against patients who did not have a smoking history recorded in their patient notes. If smoking history was recorded, the trigger on their patient record indicated they still needed to be offered help with smoking cessation. This demonstrated that the practice had a system in place to improve their performance on the delivery of national health initiatives.

Patient experience and involvement

The practice had an active Patient Participant Group (PPG). The PPG was preparing a new patient survey which would look at appointments, patients experience in reception and communication with patients. These topics demonstrated that feedback from patients was being responded to.

An action plan had been drawn up to address points raised in the last patient survey. We saw there were plans in place to introduce a display screen in the reception area that would call patients to their appointment. It was hoped that this would address points raised in the patient survey, that those people with hearing difficulties could not hear tannoy announcements clearly, due to background music.

The practice had taken steps to ensure that the annual programme of flu vaccination for patients, was delivered to patients in clinics that did not impact on the availability of GP appointments. To do this, clinics were organised on a Saturday and advertised in advance. This resulted in a high take up of the vaccine, delivered by nurses to those patients identified as being vulnerable.

Staff engagement and involvement

Staff we spoke with told us they enjoyed their work and felt well supported by the Practice Manager. A monthly team meeting, held on a weekday afternoon was attended by all staff. This gave the opportunity for staff to share any concerns and for positive feedback to be celebrated.

New administrative staff benefited from a structured induction period, which covered all areas they would work in. At the time of our inspection staff rotated on duties around the office, which they felt kept them fresh and open to learning opportunities. Staff told us the management were inclusive in making decisions about how the practice would move forward, for example in advertising any opportunities that may arise when the existing Practice Manager would retire.

The practice lead partner worked hard to ensure that registrar GPs on placement at the surgery were involved and thoroughly engaged in the delivery of all services. Registrars received an induction that followed a detailed plan and was reviewed to check it met the learning needs of each registrar.

Learning and improvement

Although all clinical staff had arrangements in place for their performance appraisal and review, there was no uniform system in place to provide the same to administrative staff. This meant review of each staff members learning needs would be difficult.

We looked at the records of continuous professional development (CPD) held by each of the practice GPs. We found these were very detailed and that learning sets took place typically each week. These were made up of a mixture of external, structured learning events, clinical and prescribing meetings, and tutorials. The CPD record detailed what learning was achieved and how it could be implemented at the practice. Where relevant, learning was shared with colleagues at the practice. As an example, we saw how GPs attended a session at a hospice, on management of pain in palliative care. This refresher training and any learning or updated guidance, was taken back to the practice and used in the training of registrars.

Are services well-led?

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

Identification and management of risk

Clinicians in the practice had systems in place to identify and manage risk in respect of patient care and treatment. There were clear lines of accountability with GP partners taking the lead on specific areas of health care and reviewing and supervising the work of registrars.

The GP partners also risk assessed areas of their work with a view to ensuring GP and patient safety, for example, when conducting home visits. All areas of each GPs work was considered when drawing up personal development plans; these were reviewed by our GP advisor who found them to be comprehensive and exceptionally detailed. We saw regular review of these was carried out by the lead partner to ensure they were effective and that the learning needs of all GPs were met. The personal development plans linked into the aims and objectives of the practice, set out in the statement of purpose for Neston Surgery.

Older people

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

Summary of findings

This population group was well supported by staff at the practice. We found that services were well led, caring and responsive to people's needs.

The practice had a GP who took the lead on dementia care and there were two practice GPs that supported local nursing homes. The partners visited each home for two hours each week to manage chronic disease and provide early interventions on other health matters. This was done in a focussed way to reduce the possibilities of hospital admissions.

In a practice booklet, available in the reception area and given to new patients on registration, it was highlighted that patients aged 75 and over would be seen by a member of the practice team for an annual check-up. If a patient could not attend the surgery, the clinician would be able to do this in a house call.

Older patients we spoke with valued the range of services offered by the practice, including the phlebotomy service and services delivered to them by practice nurses.

Our findings

Safe

The practice took steps to ensure treatment delivered to older patients was safe and that any follow up treatment was delivered as planned. Systems were in place to deliver preventative medicines and care to older patients who may be vulnerable to seasonal illnesses, such as flu. Annual health checks ensured that any underlying health matters were picked up on and treatment for these was prescribed.

Caring

All patients we spoke with from this population group expressed that their treatment and care from staff was caring and compassionate.

Effective

Two GPs at the practice took lead responsibility for the care and treatment of older patients who were living in two local residential homes. This was done in a focussed way to minimise unscheduled hospital admissions from this group of patients. A recent audit had shown the service to be effective in achieving this.

Responsive

We did find some people experienced varying levels of outcome of treatment following hospital discharge, but on closer analysis we found this to be down to boundary issues caused by postcode. The patient participant group were particularly focussed on this issue and were working with the practice partners and local clinical commissioning group (CCG) to resolve problems patients had faced. For example, if a person was discharged from Arrowe Park hospital following a hip replacement, the organisation of outpatient and physiotherapy services may fall to and be provided by Countess of Chester outpatient services. As a result of this, some patients returned home to find no services had been organised. We found a member of the CCG was working with the practice to resolve this postcode issue. In this we found GP services were acting to protect patient safety and were responsive to people who had raised this issue.

Older people

Well-led

The practice had two GPs that took the lead in delivering care and treatment to patients in nursing homes. One of these GP's also took the lead in treatment of patients with a diagnosis of dementia.

People with long term conditions

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

Summary of findings

As the patient register had increased in number, so had the demand for support for patients with long term conditions and chronic diseases. The practice had conducted some evaluation work to see how they could best meet this growing need. It was found that training a nurse to become a nurse prescriber would not necessarily alleviate the pressure on the practice caused by patient demand. The partners decided that the practice should invest further in the training of the existing three nurses, to be able to treat a number of other conditions. As an example, nurses were trained in cytology and international normalised ratio (INR) testing, which is the testing of bloods for managing dosage of the drug warfarin which allowed patients to be served by the practice, rather than be sent to outpatients' clinics at local hospitals.

Our findings

Safe

Those patients with long term conditions were often seen by a GP who they were familiar with. Nurses were available to conduct health checks that indicated whether patients medicines were still effective. We saw examples of how patients medicines were reviewed to ensure they experienced the best possible health outcomes. Repeat prescribing was managed and patient welfare was protected by this.

Caring

All patients we spoke with told us the service they received was caring and met their needs. Patients with longer term conditions were able to book appointments in advance, which allowed them to see a GP they were familiar with.

Effective

Before our inspection we reviewed data sent to us by the CCG. The data showed that hospital admissions from this patient group were no higher than those from a practice of a similar size. This would mean that the treatment of patients from this group was effective, as emergency admissions to hospital were minimised.

Responsive

The practice demonstrated how they were responsive to the needs of patients with long term health conditions. Where there had been an increase in demand for phlebotomy (blood taking) services, they had reviewed allocation of patient appointments to ensure supply met demand. A recent review of these appointments resulted in 80 sessions being made available to patients who needed them.

Well-led

The practice had a GP who took the lead on prescribing of medications. This GP attended quarterly prescribing meetings with other practices within the Clinical Commissioning Group (CCG). This ensured that

People with long term conditions

information relating to the prescription of medicines, or changes in prescribing protocols of the CCG would be shared with other GPs at the practice. This meant that patients would be both protected and treated with medicines that were recognised as those best for treatment of long term conditions.

Mothers, babies, children and young people

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

Summary of findings

The services provided by the practice met the needs of this population group and the skills of the GP partners reflected this. This enabled services to be responsive, caring, safe and effective. Childhood vaccinations were delivered by the practice and the lead GP partner had a specific interest in childhood health surveillance, supported by two other partners. The lead partner showed us how the practice worked with health visitors to deliver the Healthy Child Programme. This was a national initiative aimed at, for example, increased focus to reduce childhood obesity, improved nutrition and ensure better compliance with immunisation programmes.

Two of the GP partners were women, one of whom had specialist interest in women's health matters. This also ensured that female patients could be seen by a female GP if required, due to personal preference, cultural or religious reasons. The practice also had a well-advertised chaperone service and signs in the waiting areas expressed that patients could ask for this at any time.

Our findings

Safe

The lead partner at the practice demonstrated how the safeguarding training and policy was understood and applied by all staff at the practice. This meant that any child patient or young vulnerable adult patients subject to safeguarding plans were monitored at each clinical intervention. The practice had met its responsibilities in the submission of any reports required by safeguarding review boards, or attendance at those meetings.

Caring

Patients told us the service they received from GPs and nurses were very caring. Parents and carers of young children told us they had always had access to a GP if their child was particularly unwell.

Effective

Services delivered to this age group were effective. We saw how GPs at the practice worked well with health visitors and other community based clinicians to share information when appropriate to ensure the best possible outcomes for patients. GPs and heath visitors worked together to deliver the Healthy Child Programme, which focussed on timely interventions to promote children's health and well-being.

Responsive

The practice was responsive to the needs of all within this population group. The layout and design of facilities at the practice assisted mothers and carers of children, who may need to use double pushchairs. For example parents or carers with twins or very young children who were close in age.

We noted the practice had several posters displayed in relation to contraception services available. There was also a number of leaflets available in the main reception area. The practice offered Chlamydia checks as an enhanced service for 15-24 year olds. A poster promoting this was displayed in the patient toilets.

Mothers, babies, children and young people

Well-led

Services to this population were well led by GP partners who had lead responsibilities for each part of this age group. The lead GP partner had a specific interest in childhood health surveillance, and was supported in this by two other partners.

Working age people (and those recently retired)

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

Summary of findings

Data we reviewed before our inspection showed that patients from this population group had commented that ease of access to appointments was difficult when phoning the practice. We were able to speak with two patients from this age group on the day of our inspection who told us this was still the case. However, both patients told us the service they received from their GP was very good.

We found a programme of routine vaccinations were available to patients deemed to be at risk in this population group, or patients who were from key occupations. For example, vaccination against flu or shingles. There were also clinics run for weight management, smoking cessation, family planning and contraception.

We saw evidence of nurses conducting clinical audits with GPs on patients who may be at risk due to the length of time they had been on a contraceptive medication. We also saw how recent Medicines and Healthcare Products Review Agency (MHRA) alerts had been responded to by nursing staff, in their review of patients on contraception pills who may also use herbal remedies, which could reduce the efficacy of their medication.

Our findings

Safe

The practice had measures in place to ensure that patients from this population group received care and treatment that was safe. Medicine reviews with practice nurses were available to patients who required on-going prescribed medication. If medicine dosage or type needed to be changed, patients would be referred to a GP. We saw evidence of nurses conducting clinical audits with GPs on patients who may be at risk due to the length of time they had been on a contraceptive medication.

Caring

All patients we spoke to described staff, GPs and nurses as caring and considerate. Patients were confident that confidentiality was protected and staff in reception areas were considerate when dealing with sensitive patient information.

Effective

Services for this population group met patients' needs and were effective. Vaccinations were available to patients deemed to be at risk in this population group, for example vaccination against flu or shingles.

Data available to routine us before our inspection showed gaps within this group of patients, where patients had yet to seek treatments and respond to health initiatives, such as smoking cessation groups and support. At the time of our inspection we found no examples of how the practice had picked up these issues and proactively advertised particular clinics on a rotational basis, to encourage attendance and uptake of treatment.

Responsive

On the day of our inspection we were able to speak to patients in the waiting area that were taking time away from work to attend an appointment at the practice. A number of people told us that whilst they were happy with the service they received from their GP, they found the appointment waiting time was beyond what they had anticipated, which resulted in them taking far more time away from the work place. For example, if a GP was very

Working age people (and those recently retired)

late running, patients were expected to accept this rather than insist that they be seen at the appointed time, or within 15 minutes of the appointed time. Data we reviewed before our inspection showed that patients from this population group had commented that ease of access to appointments was difficult when phoning the practice. Two patients we spoke with on the day of our inspection told us that this was still the case.

Well-led

The skills of the clinicians at the practice met the needs of this patient group.

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

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

Summary of findings

We were told that in the geographical area that the practice covered, there were no traveller sites or prevalence of homeless people.

The practice did have a lead GP and nurse for the support of patients with learning disabilities and the practice kept an up to date register of these patients. This enabled the practice to request patients who experienced learning disabilities to attend the surgery for a full annual check-up of their physical health and well-being. The allocation of a specific GP and nurse for this population group allowed continuity of care and treatment for a population group that may suffer if they are not familiar with the people who provide their care and support. In this respect we found the practice had taken steps to respond to the particular needs of this group of patients. In the information we reviewed before our inspection, we found there were no complaints from the carers, support workers or advocates of patients with learning disabilities, which suggested that the way in which services were delivered to this population group were effective.

Our findings

Safe

The practice had robust safeguarding procedures in place, which protected any patient who may be vulnerable due to their population group or health condition. Staff demonstrated their knowledge and awareness of those procedures. We saw training in safeguarding for clinicians and staff was up to date and reflected best practice guidelines.

Caring

We were unable to speak to any patients from this population group. We observed that staff at the practice were caring and compassionate to all patients who visited the practice. The allocation of a specific GP and nurse for this population group allowed continuity of care and treatment for a population group that may suffer if they are not familiar with the people who provide their care and support. In this respect we found the practice had taken steps to respond to the particular needs of this group of patients.

Effective

The practice had a GP that lead on care and treatment of patients with learning disabilities. Patients from this population group were offered annual health checks with their GP. This helped protect the welfare of people who may overlook their physical health. In the information we reviewed before our inspection, we found there were no complaints from the carers, support workers or advocates of patients with learning disabilities, which suggested that the way in which services were delivered to this population group were effective.

Responsive

The new practice manager confirmed that all staff were aware of the Equality Act and had received equality and

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

diversity training. This meant staff understood the problems faced by patients within this population group and acted in an inclusive way to enable timely access to healthcare for all.

Well-led

The practice was well led in the care of patients with learning disabilities. We saw that staff treated all patients with dignity and respect. Staff demonstrated their understanding of the Equality Act and how they could offer help to patients from this population group, for example with making appointments with GPs with lead responsibility for this patient group.

People experiencing poor mental health

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

Summary of findings

The practice had two GP partners who took the lead on treating patients who experienced poor mental health or any mental health conditions such as dementia. A patient we spoke with in the waiting area, who fell within this population group, was kind enough to share their experiences of the practice with us. They spoke very highly of the care and compassion which the GPs and all staff had showed them when they had experienced problems related to their mental health. They confirmed that they were afforded continuity of care by seeing the same GP on each visit. They also expressed how important this had been to their recovery and how staff always found ways to offer consultation appointments to achieve this.

Our findings

Safe

The practice kept a register of those patients diagnosed with a mental health condition. These patients were called for regular health checks which they may otherwise overlook or forget.

Caring

When we looked at how administrative support staff dealt with patients, we found they were respectful and treated all patients they met in a caring and compassionate manner. A patient we talked to spoke of the care and compassion which the GPs and all staff had showed them when they had experienced problems related to their mental health. They confirmed that they were afforded continuity of care by seeing the same GP on each visit. They also expressed how important this had been to their recovery and how staff always found ways to offer consultation appointments to achieve this.

Effective

We asked about training for staff who dealt with patients with mental health conditions that could affect their behaviour. We asked about this as some of the complaints raised in the past 12 months had mentioned that patient behaviour could possibly be due to a patient's health condition. The person who was due to take on the role of practice manager told us they were looking to send staff on a 'reception master class' but were unaware if the course covered dealing with patients who may be experiencing mental health problems or dementia. They agreed that training in this area could increase staff understanding and awareness of patient behaviours that could be viewed as challenging.

Responsive

When we asked patients who fell into this group about their experience of care and treatment at the practice, they told us they had been well supported by their GP. They told us that following any hospital admission they had been contacted by their GP who offered further care and support.

People experiencing poor mental health

Well-led

We found care and treatment for people in this population group was well led. The practice had two GP partners who took the lead on treating patients who experienced poor mental health or any mental health conditions such as dementia. Staff understood the importance of confidential patient notes and markers on them, which meant out of hours services, were aware if the patient experienced mental health problems. This meant any behaviours displayed could be better understood by any locum GP called to treat a patient affected by mental health problems.