The Misterton Group Practice

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

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Overall summary

We carried out an announced inspection visit on the 4th March 2015. The overall rating for the practice is good. Specifically, we found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service. Evidence we reviewed demonstrated patients were satisfied with how they were treated and this was with compassion, dignity and respect. It also demonstrated the GPs were good at listening to patients and gave them enough time.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

It was evident good staffing levels were in place and there was an appropriate mix of skills within the team. We found staff recruitment was managed well with all the required checks in place and there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. The practice had carried out supervision and appraisals for staff. We saw staff had received training appropriate to their roles.

There were regular clinical meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led.

There was a long standing visible management team, with a clear leadership structure. Staff felt supported by the management team. There were good governance arrangements and systems in place to monitor quality and identify risk. They held regular governance meetings.

The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, performance reviews and attended staff meetings and training events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients.

Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. They had a range of enhanced services, for example in dementia support. They were responsive to the needs of older people, and offered home visits, longer and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

We found the practice completed full health checks on new patients and follow on support for any identified health needs. Special clinics for health needs such as, diabetes and asthma were held and systems were in place to identify patients who met the criteria to attend.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients..

There were systems in place to identify and follow up children living in disadvantaged circumstances and may be at risk, for example, children and young people who failed to attend appointments or clinics. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students).

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had extended opening hours through the week to support this patient group. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable.

The practice held a register of patients with learning disabilities and carried out annual health checks for this group. The practice also offered longer appointments for vulnerable patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. We saw evidence of practice staff advising and signposting vulnerable patients to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good

We saw the practice monitored patients with poor mental health; they used audits to help ensure patients had a regular physical health check and follow ups if there was non-attendance.

The practice offered structured reviews to all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental health, medicines and revision of their agreed care plan. A mental health support group was held at the practice.

Summary of findings

What people who use the service say

In the most recent information from Public Health England 2013/14 showed 85% of people would recommend this practice to others 87% were happy with the opening hours.

We received four completed patient CQC comment cards and spoke with four patients on the day of our visit. These patients were positive about the care provided by the clinical and reception staff. They felt the doctors and nurses were competent and knowledgeable about their health needs.

The practice had an active Patient Participation Group (PPG). We spoke to a member of the PPG during our visit. They told us they had conducted their own patient's survey in 2013 and there was also a suggestion box in the practice waiting room. The practice had responded to the patients' survey and to individual suggestions by improving the telephone system and expanding the range of options to make appointments and order prescriptions.

The Misterton Group Practice

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 Practice Manager Specialist advisor.

Background to The Misterton Group Practice

Misterton Group Practice is located in the rural area of Misterton approximately ten miles from the centre of Bawtry. The building is owned by the practice and has good parking facilities and disabled access. The practice also has a satellite branch based in Gringley-on-the Hill. This was visited as part of this inspection.

The practice is registered with the CQC to provide the following regulated activities: Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury; and Surgical procedures. It provides patient care for 5907 patients under a general medical services (GMS) contract with NHS England in the Bassetlaw Clinical Commissioning Group (CCG) area.

The practice has two GP partners (male), one advanced nurse practioner (female), two practice nurses, one healthcare assistants, four dispensers and an experienced administration and reception team. The reception team consists of one practice manager and 10 reception and administrative staff.

The practice is open Monday to Friday from 8:30 am to 6:30 pm. The Gringley-on-the Hill site is open Monday to Fridays 8:30am to 12:30 noon and Monday and Tuesday 6:30 to 8pm.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hour's provider service of Derbyshire Health Care.

The practice population is made up of a predominately older and working age population between the ages of 40-70 years. Fifty three per cent of the patients have a long-standing health condition.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 4th March 2015. During our visit we spoke with a range of staff including the practice manager, GP, advanced nurse practioner, practice nurse, dispenser and four reception staff. We also spoke with four patients on the day.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed four CQC comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus on better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had a rating of 98.6%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate. For example staff had raised concerns about breaches in security at the practice where a consulting room door had been left open and there was potential access to confidential information. A review had been held and systems put into place to minimise future risk.

Learning and improvement from safety incidents

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. We saw incidents were discussed at weekly GP and monthly practice meetings. We talked with staff who confirmed any important information was passed onto them either via email or directly at team meetings.

We saw evidence of action taken for example where information was not recorded on a patients record following a telephone call to the practice. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. Staff told us they felt confident in raising issues with the GPs and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they gave.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding. We saw GPs and the advanced nurse practioner had the right level of training in place to support vulnerable patients. All other staff had completed safeguarding training and knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used practice agreed codes on their electronic case management system for children and vulnerable adults. This highlighted risks to these groups were known and reviewed. The system flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice had systems to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

There were chaperone notices displayed in the consulting rooms and a chaperone policy was in place. There was evidence of patients being offered chaperone services during consultation and treatment. We saw staff had undergone a disclosure and barring service check (DBS) to help ensure their suitability to chaperone, however we noted that some staff who chaperoned had not received appropriate training. We spoke with the provider who assured that staff had been given guidance to chaperone.

Medicines management

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential temperature failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

The branch surgery at Gringley-on-the-Hill was a dispensing practice. We checked medicines stored in the dispensary and confirmed these medicines were closely monitored and kept securely. All the medicines we checked

were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We confirmed that regular audits were in place to help ensure the safe monitoring of medications. We also saw that emergency medications at the practice were well managed however when we checked the GP's emergency bag we found that some medication was out of date and therefore not fit for use. The provider immediately replaced this medication and disposed of the out of date medicines safely. They explained that the auditing of the GP bags was delegated to a member of staff who was off sick. They told us they would immediately put robust checking systems in place to ensure out of date medications were not in place again.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely.

We saw records of practice meetings where reviewed prescribing errors were reviewed. There were systems in place to ensure GPs regularly monitored patients medication. Re issuing of medication was closely monitored, with patients invited to book a 'medication review', where required. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken.

The nurses and the health care assistant administered vaccines using Patient Group Directions(PGDs) and Patient Specific Directions (PSD) produced in line with legal requirements and national guidance. We talked with staff who confirmed they had received appropriate training to administer vaccines.

Cleanliness and infection control

We saw all areas throughout the practice were clean. We saw there were cleaning schedules in place and cleaning audit records were kept in each treatment room.

Patients we spoke with and responses from the CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control. Suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

We saw liquid soap and paper hand towels and hand gel were available in treatment rooms and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets.

We confirmed Personal Protective Equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed. Sharps receptacles were in place in the treatment rooms and containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

We looked at the Infection Control Policy in place and noted it was up to date and regularly reviewed. The practice had a lead for infection control who completed recent audits to ensure the treatment areas were safe. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place. We confirmed infection control training had been completed by all the staff and refresher training was done on an annual basis.

We noted there were some carpeted surfaces in the consultation and treatment rooms and some general wear and tear on the building. The practice had submitted a programme of works to enhance the safety of the building including new surfaces for consultation and treatment rooms which would include appropriate floor surfaces. They were hopeful that this would be in place within the year.

The practice had a legionella assessments and audit in place. This confirmed the practice was carrying out regular checks in line with their policy to reduce the risk of infection to staff and patients.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. This staff we spoke with knew the location of the equipment. We confirmed equipment was checked regularly to ensure it was in working condition. A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw other equipment was tested and maintained regularly and we saw equipment maintenance logs and

other records confirmed this. We saw the practice had annual contracts in place for portable appliance tests (PAT), Gas and Electrical safety and also for the routine servicing and calibration, such as spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy in place. The policy stated all clinical staff should have a Disclosure and Barring Service (DBS) check and two references from their previous employment. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff starting work.

We saw all staff had induction training and were provided with a staff handbook. Locum GPs working at the practice were checked against the performers list to ensure they were safe to work at the practice. We also saw these GPs received a 'locum pack'. This was to ensure they had important information readily available to help ensure the on going safety of the patients.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practise.

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness. We saw evidence of succession planning to help ensure there was sufficient staff recruited to provide safe and effective care.

Monitoring safety and responding to risk

The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents. There were arrangements in place to protect patients and staff, from harm in the event of a fire. This included designated staff roles and appropriate fire equipment checks regularly carried out.

The practice was positively managing risk for patients. Patient risk stratification meetings were held to review on going risk. Patients with a significant change in their condition or new diagnosis were also discussed at clinical and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk. Staff met regularly with palliative care support agencies such as the Macmillan nurses to ensure patients had consistent and timely support. We saw information regarding palliative care patients was made available to out of hours providers so, they would be aware of changing risks.

Arrangements to deal with emergencies and major incidents

We saw evidence all staff had received training in Basic Life Support. This was updated annually. There was an automatic external defibrillator (AED) in the practice. All staff knew where this was kept and how it should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location.

We saw evidence of where the practice staff had managed an emergency situation with a patient within the waiting room. Reception and clinical staff had safely managed this emergency.

We saw there were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. This provided information about contingency arrangements, staff would follow in the event of a foreseeable emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 98.6 per cent of the QOF framework points in year 2013-14, which showed their commitment to providing good quality of care.

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practice were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw patients were appropriately referred to secondary (hospital) and community care services. The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. Feedback from patients confirmed they were referred to other services or hospital when required

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. This helped to improve patient care by ensuring clinicians based their judgements on the best possible information available at any given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers, for patients with long term conditions. These included asthma and diabetes and were used to arrange annual, or as required, health reviews. The practice had identified there was a high prevalence of diabetics in their patient population. To enable them to manage this risk to patients effectively they held regular diabetic and podiatry clinics.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included cholesterol medication and antibiotic prescribing and management of chronic kidney disease. The practice was making use of clinical audit tools to reflect on the outcomes being achieved and areas where these could be improved.

Staff regularly checked that all routine health re assessments were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multi-disciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The patients we spoke with were complimentary about the staff. We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for

Are services effective?

(for example, treatment is effective)

example basic life support, safeguarding and infection control. Staff had been trained in areas specific to their role for example, cervical screening, and wound management, smoking cessation, diabetes and COPD.

We saw evidence of regular 'BEST' training which clinical staff attended externally and other staff in house. We saw the practice kept an accurate account of training completed or training requiring an update.

All GPs were up to date with their continuing professional development requirements. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development was up to date.

The clinical and non-clinical staff confirmed they had appraisals. They told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with were unanimous they were well supported in their role and confident in raising any issues with the practice manager or the GPs. Staff had access to a confidential help line to support them if they had concerns and need to speak to someone outside the practice.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw examples of where these procedures had been put into place.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. Treatment information from hospitals and OOHs services was received and reviewed as per the practice policy. The GP who saw these documents and results, was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, midwives, school nurses and community mental health teams to support patients.

The staff attended multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used 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. Electronic systems were also in place for making referrals.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients including signposting services available and the latest practice news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties with respect to these. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including escalating this for further advice to a senior member of staff where necessary.

They were aware of how to access advocacy services. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

Are services effective?

(for example, treatment is effective)

.We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments checked whether children and young people had the maturity to make decisions about their treatment.

Health promotion and prevention

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

The practice had also identified the smoking status of patients over the age of 16 and actively offered clinically-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months had decreased.

The practice raised patients' awareness of health promotion. This was in consultations, via links on their web site and leaflets in the practice. This information covered a variety of health topics including diabetes, smoking cessation, weight management, stroke and diabetes. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The practice switchboard was located in an area away from the reception so calls could not be overheard. The staff we spoke with told us they were always careful about the questions they asked patients at the reception desk. They were aware of the need to maintain confidentiality. We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. The staff were familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard.

In the GP survey undertaken in 2014 the practice rated at 97% in patients responding that they had confidence and trust in the GP or nurse they last saw at the practice.

Patients' on going emotional needs were supported. A counselling service was offered at the practice and a mental health support group met regularly for the on going emotional support of patients. Patients were offered information and support for areas such as; bereavement counselling, mental health support and support with conditions such as cancer. Staff confirmed GPs always contacted and visited patients after a bereavement in their family to offer condolences and further support.

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2013-14, 81% of respondents said the GP was good or very good at involving them in decisions about their care. They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found staff communicated with patients so they understood their care, treatment or condition. We received positive comments from patients confirming they understood their treatment and options were discussed during their consultation.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us staff were caring and understanding when they needed help and provided support when required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

Extended appointments were made available for people who needed them and those with long term conditions.

The practice had a higher percentage of older patients than other GP practices in the CCG area. We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. Older patients were recalled if they had not been seen within a 12 month period to review their health needs. We saw that patients between 70 and 79 were offered shingles vaccination and flu vaccinations were in place.

There was a register of the housebound and patients who required palliative care. We saw that they supported patients with home visits and medications were delivered to the housebound and other patients who found it difficult to get to the surgery.

We also saw the practice provided support to three care homes in the area and visited on a regular basis.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to diabetes care, podiatry support, smoking cessation and advice on weight and diet.

Families with children and young people were supported with emergency appointments when required. Babies were seen at eight weeks for a physical examination and they had a full programme of vaccinations and immunisations. Contraception and sexual health support was also provided. Patients with immediate, or life-limiting conditions, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

The practice completed annual reviews and home visits to, two care homes for patients with learning disabilities. Extended appointments were provided to this patient group and a named GP and nurse put into place.

The practice provided support to patients who experienced poor mental health. A mental health register is maintained and 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan. Eighty Five per cent of patients diagnosed with dementia had a care plan that had been reviewed with the GP in the last 12 months.

We saw the practice worked with a local mental health support group and had recently introduced a mental health support group 'Let's Talk Well Being'. This was a group who met weekly and were being accommodated by the practice.

Tackling inequity and promoting equality

There was level access to the building and accessible toilets. Disabled parking bays were available. The waiting area was large enough to accommodate patients who used wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice did not have patients with differing language needs. However staff told us translation services were available if required.

The practice provided emergency appointments to visitors to the area when required.

Access to the service

Of the patients who participated in the national GP patient survey in 2013-14, 87 % of patients reported a good overall experience of making an appointment at the practice.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available.

The practice offered telephone and on line pre bookable appointments. Patients could also ring on the day for emergency appointments. Patients we spoke with told us they always got an appointment the same day if it was an emergency. All children were seen the same day and usually within two hours of contacting the practice. Older patients were also seen the same day and home visits were

Are services responsive to people's needs?

(for example, to feedback?)

available when required for housebound patients. The practice guaranteed a routine appointment within two weeks for non-emergency appointments. Patients could access the GP for telephone advice if attending the practice was difficult.

We saw good systems were in place to help patients order repeat prescriptions. Patients could use the web site, telephone or visit the surgery to order prescriptions.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception and displayed in the reception area. There was a suggestion box in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice manager kept a log of complaints about the practice. We looked at the complaints over the past 12 months. We saw these complaints were investigated and concluded in accordance with the practice's guidelines and procedures.

Are services well-led?

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

Our findings

Vision and strategy

We spoke with nine members of staff and they all understood their role and their responsibilities. We saw staff met regularly but noted the practice did not meet as a whole team at any stage. The practice staff were therefore not able to jointly reflect within the team and be part of the planning and shaping of the future of the practice. We spoke with registered manager who told us it was only recently that joint meetings had ceased due to additional meetings taking up the schedule. They agreed they would now re introduce these meetings to promote the dissemination of information and shared values and ethos in the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to all staff. We looked at three of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was clear management structures in place. Allocation of responsibilities, such as lead roles were in place they included safeguarding, clinical governance and infection control leads.

We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at clinical 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 in relation to the management of medicines and vaccines.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt valued and supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were happy to raise concerns or issues with their manager.

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

The practice had gathered feedback from staff, through staff meetings, staff appraisals and discussions.

The practice surveyed the patient population with a qualitative questionnaire and took action from these results. For instance they had taken action to improve access to appointments. We also saw a suggestion box was in place and any comments received were acted upon.

The practice had an active patient participation group (PPG). We had positive feedback from the PPG regarding their role with the practice and their on going engagement to improve the quality of the service for the patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring.

We looked at three staff files and saw regular appraisals took place. Staff told us they were given protected time to undertake further training and overall there was a positive approach to further development of staff.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.