Spring View Medical Centre

Quality Report

Mytham Road
Little Lever
Bolton
BL3 1HQ
Tel: 01204 578128
Website: www.springviewmedicalcentre.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Spring View Medical Centre on 4 December 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspected a number of practices in the area overseen by Bolton Clinical Commissioning Group (CCG).

The overall rating for Spring View Medical Centre was good.

Our key findings were as follows:

- Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control.
- The practice had systems in place to ensure best practice was followed. This is to ensure that people's care, treatment and support achieves good outcomes and is based on the best available evidence.
- Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.
- Patients spoke positively in respect of accessing services at the practice. A system was in place for patients who required urgent appointments to be seen the same day, and extended hours appointments were available daily.

We found an area of outstanding practice. Extended hours appointments were available until 10pm on weekdays and 1pm during weekends and on bank holidays. Patients attended a nearby practice for these appointments, and the GP they saw had access to all their electronic medical records which were updated at the time of the appointment.

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

The provider should:

- Ensure staff knew the procedure to follow when carrying out chaperone duties.

Summary of findings

- Ensure Disclosure and Barring Service (DBS) checks were carried out for all appropriate staff, including those carrying out chaperone duties.
- Ensure staff training, including on-line training was effective.
- Consider having oxygen or a defibrillator available for use in an emergency and have a risk assessment in place if it was decided not to have these items.

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. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute of Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Appraisals and personal development plans for staff were up to date.

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 also 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. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with their preferred GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was communicated to staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Regular meetings for all staff were held. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a patient participation group (PPG) that was communicated with by email. Staff had received inductions and had regular performance reviews and appraisals.

Summary of findings

What people who use the service say

We received 27 completed patient comment cards and spoke with five patients at the time of our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed CQC comments cards were mainly positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their privacy and dignity was maintained. Patients told us they received excellent care in a friendly manner. They said they felt GPs listened to their concerns.

We also looked at the results of the latest national GP survey. The survey results included:

92% of respondents found the experience of making an appointment as good.

85% said they could usually make an appointment with their preferred GP.

96% found it easy to get through to the practice on the telephone.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff knew the procedure to follow when carrying out chaperone duties.
- Ensure Disclosure and Barring Service (DBS) checks were carried out for all appropriate staff, including those carrying out chaperone duties.
- Ensure staff training, including on-line training was effective.
- Consider having oxygen or a defibrillator available for use in an emergency and have a risk assessment in place if it was decided not to have these items.

Outstanding practice

- Extended hours appointments were available until 10pm on weekdays and 1pm during weekends and on bank holidays. Patients attended a nearby practice for these appointments, and the GP they saw had access to all their electronic medical records which were updated at the time of the appointment.

Spring View Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Spring View Medical Centre

Spring View Medical Centre is a single storey purpose built practice located in the centre of Little Lever.

There are three GPs working at the practice. Two work full time and one works part time. Two are female and one is male. There is also a practice nurse, a healthcare assistant, a practice manager, a health trainer, and administrative and reception staff.

The practice is open from 8.30am until 6.30pm every Tuesday, Thursday and Friday, from 8.30am until 7.45pm every Monday and from 8.30am until 1.30pm every Wednesday. Extended hours appointments were available daily in a nearby practice.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 4813 patients were registered with the practice.

Spring View Medical Centre had opted out of providing out-of-hours services to their patients. This service was provided by a registered out of hours provider.

Why we carried out this inspection

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

How we carried out this inspection

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. These groups are:

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

Detailed findings

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 the 4 December 2014. We reviewed all areas that the practice operated, including the administrative areas. We received 27 completed patient comment cards and spoke with five patients during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with two GPs, the healthcare assistant, the practice manager and members of the reception team.

Good

Are services safe?

Our findings

Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents, including mistakes were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Bolton Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others. We saw that incidents from throughout the CCG area were looked at and analysed to see if there were any patterns. The CCG was able to provide further information and updates on incidents when requested.

The staff we spoke with were aware of how to report significant events. We saw evidence that significant events and safety alerts were a regular agenda item for the practice meetings. All events were discussed openly with learning points disseminated to staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred. We saw that national patient safety alerts and significant events were a regular agenda item at practice meetings and they were openly discussed with all staff. There was evidence that the practice had learned from these. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw an example of new guidance that had been received regarding certain vaccinations for patients going abroad. This had been discussed and the practice had put in place a system for ensuring patients were given a certificate as proof they had received a vaccination. We also saw an example of systems being put in place following a significant event occurring. This had been discussed at a practice meeting and all staff were aware of the new system that was in place.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. A flowchart for reporting concerns was displayed in clinical rooms and relevant contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to the appropriate level (level three), and the other GPs were booked to have level three training. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy in place. This stated staff should have received on-line training prior to carrying out chaperone duties. It also stated staff should stand inside the curtain while chaperoning during an intimate examination. The staff we spoke with told us there were occasions they acted as a chaperone, and they had received on-line training for this. However, their understanding of their duties as a chaperone varied. Some told us the need for them to be inside the curtain an observe examinations had not been explained to them. One staff member told us they never saw the patient while they chaperoned.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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 at all times.

We saw evidence that medicines and prescribing were discussed at the regular practice meetings. Updates were disseminated to all relevant staff. We saw the practice was due to start face to face reviews of all patients who required 10 or more medicines to make sure they were prescribed the most appropriate medicines for their conditions.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. Training for staff had been provided by the infection control lead at the CCG. Online training was also provided.

We saw evidence that the lead carried out annual infection control audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that infection control was discussed when required so staff could receive timely updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had identified that testing for legionella (a germ found in the environment which can contaminate water systems in buildings) was required. We saw evidence that this was in the process of being arranged.

Equipment

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

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. There was also guidance on what procedure to follow if a previous conviction was disclosed by an applicant or a Disclosure and Barring Service (DBS) check identified a previous conviction. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. These included evidence of identity, references and a full work history. Checks were carried out to make sure clinical staff were registered with the appropriate professional body, for example the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC).

DBS checks had been carried out for clinical staff. However, the practice manager told us they had not carried out checks for reception staff even though they occasionally asked to chaperone patients.

We saw a risk assessment to determine safe staffing levels was in place. This also provided information about how cover was to be provided of staff were absent at short notice.

Good

Are services safe?

Staff told us they had followed an induction programme when they had started work. A checklist had been completed as evidence that new staff had completed their induction when they started work.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included six monthly full checks of the building and environment and monthly checks of the fire alarm. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that any risks identified were discussed during practice meetings. Plans were put in place to manage these risks and the plans were monitored by the practice manager.

We saw that the practice was following advice given by Public Health England about how to deal with suspected Ebola cases. Staff were aware of and information was displayed about the procedure to follow if it was suspected that any member of staff or patient had symptoms of Ebola. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support.

The practice did not have oxygen or a defibrillator on the premises. The practice manager told us they were considering purchasing a defibrillator for the practice. They had decided not to hold oxygen due to the close proximity of the Accident and Emergency department. However, this was just over three miles away.

Appropriate emergency medicines were available. These were kept securely and at the correct temperature. All the medicines we saw were within their expiry date. We saw that regular checks were carried out to ensure the emergency medicines were available and in-date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by the GP. We saw examples of GPs following NICE guidance and arranging for urgent tests to be carried out for patients presenting with some conditions. They then disseminated the information to other staff within the practice. Staff confirmed they received regular updates at their practice meetings.

The GPs told us they took the lead in specialist clinical areas such as diabetes, asthma and women's health. The nurse took the lead for reviewing long term conditions and we saw effective procedures in place to ensure patients were invited for a review of their condition at appropriate intervals. If patients did not attend their review the nurse telephoned them to try to make a convenient appointment. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

Discussion with GPs and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff conducted consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

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

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. There were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw evidence of the clinical audits cycles that had been carried out. These included an audit on the identification of patients with asthma or chronic obstructive pulmonary disease (COPD), and their annual review attendances. The audit cycles showed there had been a positive outcome for patients.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. GPs also attended monthly CCG GP meetings to keep up to date with any changes in the area. Information was then disseminated to other relevant staff.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. GPs carried out face to face reviews of patients who required repeat prescriptions every six months.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The majority of staff had worked at the practice for several years. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development (CPD) requirements and all either have been revalidated or had a date for revalidation.

Good

Are services effective?

(for example, treatment is effective)

(Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

We saw that the majority of training was via e-learning. The practice manager monitored training to ensure all staff had completed what was required. One staff member told us they had not completed chaperone training. When we checked their records we saw it had been completed in August 2014 by e-learning. Training records showed that six training courses had been completed on the same day within two hours and fifteen minutes. Checks were not carried out to test the understanding of staff in relation to the training they had participated in.

All staff, including the practice nurse, healthcare assistant and practice manager, undertook annual appraisals that identified learning needs. Personal development plans were put in place for each staff member and these were monitored throughout the year to ensure any learning or development requirements were met. Staff told us they felt supported at work and were able to request additional training if they thought it would be beneficial.

We saw that all new staff followed a formal induction programme. The practice manager monitored this and a checklist was in place to show when new staff had completed each part of their induction training.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. The GPs told us they reviewed the, took any appropriate action and ensured their patient records were up to date.

The practice nurse met with long term conditions nurses approximately every six to eight week where patients on the palliative care register were discussed. The practice nurse also met with district nurses. The practice manager told us their relationship with community and district nurses was good, and they often called into the practice on an ad hoc basis if they had anything to discuss.

We saw evidence that monthly meetings were held with the local community integrated care team. Participants included practice staff, community matrons and district nurses. Patients with complex needs or at a higher risk of being admitted to hospital were discussed during these meetings, and care plans were put in place where appropriate.

The practice worked with seven other practices to provide extended hours appointments for patients. This service was provided from a nearby health centre and patients could access appointments until 10pm Monday to Friday, and until 1pm during the weekend and on bank holidays. This extended hours scheme was linked to the GPs computer system so patients' records were available, and could be updated, during their appointments.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. They told us referrals were made in a timely manner.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP 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.

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice.

The practice worked with seven other practices to provided extending hours appointments for their patients. Although all patients accessing this service were seen at a nearby practice, their electronic records were available during their appointment and were updated by the GP who they saw.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and

Good

Are services effective?

(for example, treatment is effective)

treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

The 2014 GP patient survey reflected that 79% of respondents said the GP was good at explaining tests or treatments to them (CCG average 85%), and 93% said the same of the practice nurse (CCG average 77%). Also 66% of respondents said the GP was good at involving them in decisions about their care (CCG average 77%), with 89% saying the same of the practice nurse (CCG average 69%).

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We saw that the practice had various consent forms that were completed appropriately. The clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. GPs also told us how they would obtain consent for patients who had, for example, a learning disability. They were aware of who to involve in making the decision and the circumstances where a mental capacity assessment was necessary.

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms then were offered a new patient appointment with the healthcare assistant. Staff told us that most new patients attended this appointment, during which information such as the patient's height, weight, smoking and alcohol consumption status and family history usually were discussed and relevant information recorded. Advice about lifestyle was given and if required an appointment with the practice nurse or GP was arranged.

Patients over the age of 39 were invited for a health screening appointment. The practice had been offering this proactive check for over four years. Lifestyle choices were discussed and the GPs told us the tests carried out helped to identify health problems at an early stage. The current take-up rate for these appointments was 79% of eligible patients.

The patients with the highest risk of being admitted to hospital had a care plan in place. The practice nurse usually managed these with input from the GPs where necessary. Care plans were reviewed regularly to ensure information was current and the correct advice was being offered to patients.

We saw the practice had an 'at risk of diabetes' register. Any patient coded as 'at risk of diabetes' was offered an annual appointment with a health trainer, who was based at the practice. All patients aged 75 or over had a named GP, and a monthly check was carried out to ensure all relevant patients were included. A nurse attended the practice to see patients over the age of 75. They would carry out checks and assessments on patients and make referrals to other providers or a GP if required. We saw that patients who found it difficult to visit the practice had been identified and the nurse was starting to visit these patients in their homes.

A full range of vaccinations for children and adults was offered to patients. Health checks such as cervical smears were also carried out. We saw a procedure was followed for those patients who did not attend these appointments.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The patient survey showed that 70% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 87%) and 80% thought their GP was good at listening to them (CCG average 90%). The figures when asked the same about the nurse were 92% (CCG average 79%) and 95% (CCG average 81%). The survey showed that 99% of patients found the receptionists helpful (CCG average 89%), 83% thought the GP gave them enough time (CCG average 87%), and 94% thought the same of the nurse (CCG average 81%).

The patients we spoke with all gave us positive comments about all the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. Patients told us they were given enough time during their appointments and the GPs and nurses listened to them. Twenty-six of the 27 comments cards we received gave very positive comments about the practice. They commented they were treated very well by staff who went out of their way to make sure they were all right.

Patients told us that although the reception area was not very private this did not cause any problems. Reception staff did not ask them for personal details, and there was a private room available if they needed to discuss anything in confidence.

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

Care planning and involvement in decisions about care and treatment

The latest GP patient survey information showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment than the CCG average. However, the patients we spoke with told us they felt involved in decisions about their care and treatment, and the GPs always explained everything to them in a way they could understand. The CQC comments cards we reviewed also provided evidence of patients being given options about their care and feeling fully involved due to having conversations with medical professionals.

Staff told us that translation services were available for patients who did not have English as a first language. These were required very rarely at the practice.

We saw that a wide range of information about various medical conditions was available in the reception area. Information about services that were available in the area was also displayed.

Patient/carer support to cope emotionally with care and treatment

Counselling services were available in the area and GPs referred patients when appropriate. One of the patients we spoke with told us they had recently received emotional support from a GP and they had arranged for them to see a counsellor in a timely manner.

The practice identified patients who were carers and informed them of support groups in the area. This information was also available in the reception area. A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The GPs took the lead for specific conditions such as diabetes, asthma and women's health. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate interval for patients who required regular medicines.

The practice kept a register of patients with a learning disability. They were invited for an annual health check and were contacted by telephone if they did not attend.

All patients over the age of 75 were given a named GP. We saw that over 75s health checks were arranged by a nurse. These checks had been in place for over four years and had been used to identify health problems at an early stage so appropriate treatment and advice could be arranged.

Where a patient had a higher risk of unplanned hospital admittance they had a care plan in place. These care plans were monitored and updated regularly so that any increased risk could be identified and appropriate action taken.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They told us there were very few patients who did not speak English as a first language but translation services were available. The practice had identified certain groups of patients, such as those with a learning disability or with caring responsibilities, and additional help was provided in an appropriate manner. Patients who were housebound were easily identifiable and home visits were arranged for them, for example during the flu vaccination programme.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was fully accessible for patients using a wheelchair, or with a pushchair, and consultation rooms were all on the ground floor. There was an accessible toilet.

Access to the service

We spoke with five patients during our inspection. Those that had requested an urgent appointment had been given one for the day they requested it. We reviewed CQC comments cards and most patients told us they were able to access appointments urgently when required, and usually at a time convenient for them Six of those told us they had made their appointment either on the same day they attended or the previous The results of the latest national GP patient survey showed that 92% of respondents found the experience of making an appointment as good. This was above the Clinical Commissioning Group (CCG) average for the area of 77%. In addition, 85% of respondents said they could usually access an appointment with their preferred GP (CCG average 62%), and 96% of respondents said they found it easy to get through the practice by telephone (CCG average 80%).

The practice manager explained the appointments system to us. Routine appointments could be made in advance and emergency appointments could be requested at any time of the day. Young children were always given an on the day appointment if required. We saw that there were on the day appointments available for the day of our inspection and routine pre-bookable appointments were available the day following our inspection. Staff told us they thought there were enough appointments available to meet the needs of patients. During the day if it was found extra appointments would be beneficial these were arranged. Telephone appointments were also available.

The practice worked with seven other practices to provide extended hours appointments. These were held in another practice in the area but patients' records were available electronically. These appointments meant that patients who worked could be seen until 10pm during the week or until 1pm during weekends and bank holidays.

The opening hours of the practice and the availability of the extended hours appointments was displayed in the waiting area. Appointments could be made via an on-line system. This was advertised on the practice's website but the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice manager told us this was not often used. Information about where medical assistance could be sought when the practice was closed was readily available to patients.

We saw that the practice had opened during the weekend for a short time so patients could attend for their flu vaccination. A drop in session had also been arranged during a recent school holiday to make it easier for parents to bring their young children for their flu vaccination.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for managing complaints and the process was overseen by a GP. We saw that the senior receptionist usually dealt with verbal complaints and where these could not be immediately resolved they were recorded and dealt with in the same way as a written complaint.

We looked at the complaints that had been made in the 12 months prior to our inspection. We saw evidence that learning points and actions required had been identified and the method of communicating these points to staff was recorded. We saw that complaints was a regular agenda item for staff meetings and they were discussed openly.

The practice had received information from NHS England about recurring themes for complaints to GP practices. They had looked at the main points made and discussed them during a meeting. This was to ensure staff were aware of the themes and could avoid certain occurrences.

The patients we asked told us they were aware of how to make a complaint and said they would feel comfortable doing this if necessary.

Are services well-led?

Good

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

Our findings

Vision and strategy

There was a well-established leadership structure with clear allocation of responsibilities amongst the GPs and the practice team. The two partners were considering retiring in the following few years. There was a long term plan in place to recruit further GPs so there would not be a detrimental effect on patients or other staff when this happened.

GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs were committed to providing a high quality service to patients in a fair an open manner. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were aware of the practice values. Our discussions with patients and staff demonstrated that these values and targets were being met.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. Meetings were held approximately every four to six weeks for GPs, nurses, the management team and reception staff. We looked at the minutes of recent meetings. These provided evidence that performance, quality and risks had been discussed and any required actions were monitored.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. The clinical audits we saw showed that they had had a positive impact on patient outcomes.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Most staff had worked at the practice for several years.

We saw that practice staff meetings were held for all staff approximately every four to six weeks. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings, individual appraisal meetings or during the regular informal discussions that took place. They said the practice manager had an open door policy and was very approachable, as were the GPs.

Seeking and acting on feedback from patients, public and staff

The practice carried out patient satisfaction surveys. The most recent survey had been carried out in February 2014 and it asked patients about their awareness of the different services the practice offered as well as their satisfaction with different aspects of the service. The majority of responses were positive. Where issues had been identified action had been taken to address them. We saw an action plan had been put in place and this was monitored by the practice manager. At the time of our inspections all improvements that could be made had been actioned. These included communicating more effectively about how prescriptions could be ordered, reviewing the extended hours service and arranging for a better handrail to be fit at the entrance to the practice.

The practice had a patient participation group (PPG) that were communicated with by email. The PPG had been consulted about the patient survey and about how improvements could be made to the practice. The survey was due to be repeated in 2015 so any changes made could be monitored to ensure the service had improved.

Are services well-led?

Good

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

The practice had started to use the friends and family test during the month of our inspection. There was a box in the reception area for these questionnaires to be posted and these were to be reviewed each month. Staff were aware of the friends and family test, but it was too early for any results to be known.

The staff we spoke with told us the practice manager had an open door policy and they were encouraged to make suggestions about how the service could be improved. There were opportunities to put forward their ideas during the regular practice meetings, and also during their more formal appraisal meetings.

Management lead through learning and improvement

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. The majority of this was on-line training and we saw an example of several training courses being completed within one morning. Learning was not tested following the training being completed, and this example was brought to the attention of the practice manager. Staff told us they were supported in their personal development.

We saw evidence that the continuing professional development (CPD) of the practice nurse was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), indicated that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

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