Well Close Medical Group

Quality Report

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Date of inspection visit: 9 October 2014
Date of publication: 09/04/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Well Close Medical Group on 9 October 2014.

We rated the practice overall as good.

Our key findings were as follows:

- The leadership, governance and culture were used to drive and improve the delivery of high quality, person-centred care.
- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- Patients said, and our observations confirmed, they were treated with kindness and respect.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.
- The practice safely and effectively provided services for all patient groups. The staff were caring and ensured all treatments being provided followed best practice guidance. The practice was well-led and responsive to patients' needs.
- The practice was in close proximity to the accident and emergency department. To encourage patients to go to the practice they offered accident and emergency slots at the end of each surgery. The practice worked closely with the accident and emergency department.

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 service is rated as good for providing safe services. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to oversee the safety of the building and patients. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding and child protection referrals.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Are services caring?

Good

The practice is rated as good for providing a caring service. The eight patients who completed CQC comment cards and 14 patients we spoke with during our inspection were complimentary about the reception staff and clinicians. They said the staff treated them with respect and listened to their views. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Data showed patient outcomes for were either in line with, or better than average, when compared to other practices in the local CCG area. Patients were able to access appointments in a timely way. The patients reported good access to the practice and told us urgent same day appointments were always available. The practice had taken steps to reduce emergency admissions for patients with complex healthcare conditions, and older patients had been given a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to any issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision for improving the service and promoting good patient outcomes, including the making of plans to provide patients with access to their medical records. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for, and also felt well supported by management. The practice had a range of policies and procedures covering the activities of the practice, and these were regularly reviewed. Systems were in place to monitor, and improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

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 the practice had achieved good outcomes in relation to some of the conditions commonly associated with older people. The practice offered proactive, personalised care to meet the needs of older people. It provided a range of enhanced services including, for example, end of life care and a named GP who was responsible for their care. Clinical staff had received the training they needed to provide good outcomes for older patients.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions. Nationally reported data showed the practice had achieved good outcomes in relation to those patients with commonly found long-term conditions. The practice had taken steps to reduce avoidable hospital admissions by improving services for patients with complex healthcare conditions. All patients on the long-term condition registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been prepared. These included the outcome of any assessments patients had undergone, as well as the support and treatment that would be provided by the practice. The practice nurse had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, contraception and maternity services. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals, such as school nurses and health visitors. Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. New mothers had access to health clinics where child health checks were carried out by a health visitor and nursery nurse. Young people had access to advice and guidance regarding sexual health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). 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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register which identified which patients fell into this group, and used this information to ensure they received an annual healthcare review and access to other relevant checks and tests. Staff worked with multi-disciplinary teams to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise and report signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing and how to contact relevant agencies, in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice could access community mental health services. The staff were familiar with the support service available for patients experiencing poor mental health in the local area and were able to sign post patients to these services.

Summary of findings

What people who use the service say

We received eight completed patient CQC comment cards and spoke with 14 patients who were attending the practice on the day of inspection. We spoke with people from different age groups, including parents and children, patients with different physical conditions and long-term care needs. The patients we spoke with were extremely complimentary about the staff and clinicians, as were all of the comments cards. Patients told us they found the staff to be very helpful and felt they were treated with respect

What people who use the service say..

The practice had established a positive and proactive practice patient participation group (PPG). The group was established in 2007 and held regular meetings every two months. The PPG was responsible for a range of initiatives and changes, for example from the last patient survey; they suggested changes to the appointment system and those had been implemented. Changes in the environment had also been made, such as new notice boards for patient's news and information and magazines in the waiting room.

Findings from the 2013 National GP Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice.

Well Close Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a Practice Manager.

Background to Well Close Medical Group

Well Close Medical Group operates from the town of Berwick upon Tweed in the northernmost part of England, extending into Scotland. The practice has a list size of 9,800 patients, and also has a large influx of holiday makers in the summer.

Why we carried out this inspection

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

How we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the QoF (Quality and Outcomes Framework) data, this relates to the most recent information available to the CQC at that time.

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)

Information we reviewed before visiting, included 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 9 October 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013 The practice did not declare any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. We had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events and they were made available to us including the practice's most recent annual audit of them from September 2014. A slot for significant events was on the practice meeting agenda for the monthly meetings. From the minutes of these meetings we saw a review of actions relating to risk management, compliments and complaints. There was evidence that appropriate learning had taken place regarding significant events and that the findings were disseminated to relevant staff. Staff including administration, medicine management and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Once incident forms were completed they were discussed with the practice manager and risk management was regularly reviewed within the practice. We reviewed four significant event analysis (SEAs) undertaken in 2013/14 and saw records were completed in a comprehensive and timely manner. For example the process of prescribing for one patient had been re visited with staff following an incident. 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.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a dedicated GP appointed as lead in safeguarding of vulnerable adults and children who had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of the lead role and who to speak to in the practice if they had a safeguarding concern. In the practice meeting minutes we saw reference to the GP toolkit for child protection. This was available to staff and was included as part of induction for new staff. An example of an incident was given where a concern had been escalated to the GP, then to safeguarding. The GP then wrote to the safeguarding lead to ascertain all elements of the concern had been covered.

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

For patients with learning disabilities their annual reviews were undertaken by a nurse practitioner. The nurse had an extended appointment time available and was able to refer to the GP when needed.

When patients made a telephone appointment the receptionist asked if their need to see a GP was urgent. The practice had a policy of fitting appointments for babies, children and vulnerable adults into an extra clinic.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff and was undertaken by them when required.

Good

Are services safe?

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 medicines were kept at the required temperatures. This was being followed by the practice staff and staff knew what action to take in the event of a potential power failure and refrigerator malfunction.

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 practice had appointed a dispensing and medicines optimisation manager who regularly monitored and reviewed prescribing and the safe handling of medicines in the practice. We saw that regular meetings were held were prescribing, safety and medication audits were discussed. The GPs confirmed that the medicines optimisation manager continually monitored their prescribing and highlighted improvements.

There was a protocol for repeat prescriptions which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance.

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.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. 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 who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The practice manager had also signed up to do this training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out audits and that actions were identified. For example, the practice had purchased foot operated bins which were in use throughout the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. The staff were able to describe how they would deal with a spillage of body fluid. There was also a policy for needle stick injury.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and we saw evidence of calibration of relevant equipment; for example patient weighing scales. Fire equipment checks were carried out regularly and a fire risk assessment had been completed. Current gas safety and electrical installation certificates were in place.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment of staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in

Good

Are services safe?

place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included, for example, monthly and annual checks of the premises and practice equipment. The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe.

Where risks had been identified they had been documented, and actions recorded to reduce and manage the risk. Staff were able to identify and respond to changing risks to patients, such as deterioration in their health and well-being, or a medical emergency. For example, emergency processes were in place to help reduce hospital admissions for patients with long-term conditions. This included providing a RESCUE pack for patients with breathing difficulties to help them better manage their condition. (RESCUE packs contain medicines for patients with breathing difficulties to use at home in an acute exacerbation as part of their self-management strategy).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in an area that only practice staff could access. The practice nurse told us they knew the location of these. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan specifying the action to be taken in relation to a range of potential emergencies that could impact on the daily operation of the practice. Risks identified included incapacity of the GP partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to. For example, contact details of the company responsible for servicing the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidance was discussed, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work which allowed the practice to focus on specific conditions. The GPs and nurse we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this ensured that all staff continually reviewed and discussed best practice guidance around the management of certain conditions such as the management of depression. Review of clinical meeting minutes confirmed this happened. Staff providing gynaecology and family planning services received regular updates about this service. The practice employed two phlebotomists who along with taking blood samples were qualified to monitor physical health such as blood pressure.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to and for children and young people Gillick assessments were completed. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

We saw evidence that the practice's performance for prescribing was regularly reviewed and this was comparable with the CCG. One of the GP's was the lead for medicine management. We saw from the medicines optimising meetings that the practice was continually reviewing patients to ensure patients received evidence based treatment.

The practice identified patients with complex needs who had or required multidisciplinary care plans and these were documented in their case notes. We saw that these had been discussed at the practice meeting which stated the plans were being entered into the patient's notes and a copy sent to the patient.

The practice had carried out an audit relating to the number of admissions to hospital from the care homes in their area. Within the practice each GP had a number of care homes on their list. The homes were visited every fortnight, as well as emergency call outs. A further audit carried out after 6 months showed that there had been significantly less admissions to hospital from these care homes

We were shown the process the practice used to review patients recently discharged from hospital and to ensure medication changes were reviewed. We saw that the practice continually reviewed and monitored patient's hospital admissions and the findings were discussed monthly with the GPs and Practice manager.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral to secondary care and patients with suspected cancers referred and seen within two weeks. We saw evidence that regular review of elective and urgent referrals were undertaken by the practice.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. The practice offered patients with long-term conditions, such as hypertension, heart disease and chronic obstructive pulmonary disease, access to appointments of varying lengths depending on the reason for the visit.

Good

Are services effective?

(for example, treatment is effective)

The practice also worked closely with the local hospice and had advanced care plans in place for those patients who required that. A traffic light system was used which assisted in identifying what patients needed in terms of an increase in care at home or admission to the hospice. Care plans identified the patient's preferred place to be.

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

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly completed clinical audits on their results and used that as part of their learning.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was performing above the national and local average.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs should undertake at least one audit per year.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the clinical staff with doctors specialising in different areas, for example one GP specialised in minor surgery and joint injections. The practice teaches GP registrars and final year medical students and there was one GP trainer in the practice. We saw that the practice was actively involved in research and there was a lead GP responsible for this. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation). Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses required for their professional development.

Practice nurses and nurse practitioner had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and smoking cessation. Those with extended roles such as the practice nurses were seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries, and information from the out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and auctioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The nurse manager from the practice was also the chairman of the Practice Nurse Forum. A meeting was held bi monthly and any concerns from practices could be raised along with sharing good practice. The outcome from that meeting was then fed into the CCG monthly meeting.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book outpatient appointments with their chosen hospital with the help of the practice secretary. Staff reported that they monitor referrals to check if anyone has missed an appointment and follow this up with a call to the patient.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health Promotion & Prevention

The practice nurse told us they carried out a health assessment with new patients. Any health concerns identified would be flagged up with the GP partners to be followed up. The practice offered NHS Health Checks to all its patients aged 40-75 years. This NHS programme aims to keep patients healthier for longer.

The practice was good at identifying patients who needed additional support and were pro-active in offering extra help. For example, there was a register of all patients with learning disabilities. Nationally reported data for 2013/14 showed that patients with Down's Syndrome had received a particular healthcare test in the preceding 12 months. The practice manager confirmed that all patients with learning disabilities had received an annual health care check during the same period.

Steps had been taken to identify the smoking status of patients over the age of 16, who came into contact with the practice. We were told the practice actively offered nurse-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 previous 12 months was 29. This was above average compared to neighbouring practices and national figures.

To encourage attendance for cervical smears the practice had commenced sending letters/appointments written on pink paper. This was in the early stages and an audit would be carried out after 6 months to see if there had been any uptake in number of smears carried out. The nurse told us they were responsible for carrying out cervical smears and had received training to do this. They also said they took every opportunity to offer smear testing to patients who had previously failed to take up the offer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders.

Good

Are services caring?

Our findings

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013 National GP Patient Survey, and a survey of patients undertaken in 2013 by the practice's PPG. The evidence from these sources showed that the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Data from the National GP Patient Survey showed the practice was rated above the regional CCG average in most of the areas covered. For example, of the patients who responded: 88% said the last GP they saw, or spoke to, was good at giving them enough time; 88% said the last nurse they saw, or spoke to, was good at listening to them; 89% and 90% of patients said both the last GP and nurse they saw, or spoke to, was good at treating them with care and concern respectively.

We received eight completed CQC comment cards. The feedback was positive and no concerns were raised. We also spoke with 14 patients on the day of our inspection. We spoke with people from different age groups, including parents and children, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurses were competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

We saw that staff spoke with patients in a quiet and confidential manner. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained patients could also ask to speak with staff in private.

Respect, Dignity, Compassion & Empathy

Patients told us the practice offered a good service and staff were excellent, helpful and caring. They said staff treated them with dignity and respect, and were satisfied with the care provided by the practice.

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

Care planning and involvement in decisions about care and treatment

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations. Written consent was obtained for minor surgery. The patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted. The national GP patient survey (December 2013) found that 88% of patients said they were fully involved in making decisions.

The practice had an 'access to records' consent policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information about the policy was available for patients on the practice website and in leaflets.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

We saw that the staff had detailed knowledge of the patients they served and kept registers in respect of who had learning disabilities; carer responsibilities; mental health needs and complex health conditions. Staff provided additional support mechanisms for these people such as home visits; organising early appointments for nervous patients; arranging appointments around carer's availability.

We saw evidence that the practice works jointly with the health visitor and school nurse to address the needs of children and families in the 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. During the summer months the practice was aware that there would be an increase in patient numbers on a temporary basis due to holiday makers visiting the area and planned ahead accordingly.

The practice held information about the prevalence of specific diseases such as coronary disease; respiratory disease and also completed disability registers. This information was reflected in the plan for the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations. Often the GPs would schedule routine home visits for these patients to ensure they received treatment in a timely manner.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services for example, those patients with a learning disability, travellers and carers. The practice was able to identify different patient groups and respond to their needs. The practice actively promoted services available to people in the local community for example the walk in flu clinics.

The premises at the surgery had been adapted to meet the needs of people with disabilities accessing the service. There was sufficient space in the practice to accommodate patients with wheelchairs and prams and to allow easy access to treatment and consulting rooms. Accessible toilet facilities were available for all patients. An audio loop was available for patients who were hard of hearing.

Access to the service

Appointments were available from 8:30am to 6:00pm each weekday. Patients were able to book appointments either by telephone, visiting the practice or on-line via the practice web site. The practice remained accessible to patients throughout the working day, except at those times where staff training had been arranged, which was 1 hour every month.

Information about how to access urgent appointments was available on the practice website. This included a commitment that all requests for same day urgent care would be met. Telephone appointments were triaged by the duty GP. Patients were able to book appointments in advance. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed which was provided by telephoning 111. Information about how to access out-of-hours care and treatment was available on the practice website and on the practice leaflet. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Listening and learning from concerns & 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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There was information available about complaints and a form patients could complete about complaints, suggestions and concerns.

The practice reviewed complaints and compliments on a monthly basis. We saw that complaints were investigated, shared with staff and lessons learnt from individual complaints had been acted upon.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. We looked at one complaint received between 2013/14. We looked at the records of this complaint and

Good

Are services responsive to people's needs?

(for example, to feedback?)

found it had been handled satisfactorily, dealt with in a timely manner and to the satisfaction of the patient concerned. We saw the practice had offered an apology on behalf of the practice team. We were able to see that improvements had been made following the complaint received.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. In the patient information it stated 'The team work together to provide the highest quality healthcare at the same time meeting ever changing needs of its patients and the community'. The practice also set out 'expectations' the practice aims for, for example a caring attitude to patients' problems and a willingness to work with the patient to resolve their problems.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw and were told that staff regularly came together at a range of formal meetings to discuss practice business, training, future developments and patients ongoing care.

Governance Arrangements

The practice had a number of policies and procedures in place concerning its activities and the services it provided to patients. Staff were able to access these via the practice website. The sample of policies and procedures we looked at had been recently been reviewed. The practice held regular practice management, clinical and multi-disciplinary meetings. Minutes of recent meetings indicated the performance of the practice was reviewed and discussed.

The practice used data from the QOF to measure their performance. This showed the practice was performing in line with practices nationally. We saw that QOF data was discussed at practice management meetings. This helped to ensure all staff were aware of how the practice was performing and to reach consensus about any actions that needed to be taken. QOF data confirmed the practice participated in an external peer review with other practices in the same CCG group, in order to compare data and agree areas for improvement.

The practice had completed a number of clinical audits. For example, it had carried out an audit of its prescribing practice in relation to the use of a particular medicine with high risk patients. Information made available to us during the inspection regarding the outcome of this audit indicated the practice had made changes to their prescribing practice which had resulted in positive outcomes for this group of patients.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, an up-to-date fire safety risk assessment was in place, and there were risk assessments to minimise the risks associated with the use of IT equipment.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead manager for medicines management and two safeguarding leads for adults and children. We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies such as induction policy, recruitment and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required and felt confident in speaking with the management team who they told us were supportive.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, and complaints and compliments received which they shared with staff. We looked at the results of the annual patient survey and saw the overall patient satisfaction was high with patients saying they would recommend the practice to a friend.

The patient participation group (PPG) were very active and had steadily increased in size. The group was well established and had representatives from various population groups. The group produced an annual report and actively communicated with patients.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

Good

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place where training was discussed. Staff told us that the practice was very supportive of training and staff could access courses they required to fulfil their roles and responsibilities.

The practice was a GP training practice and teaches GP registrars and final year medical students. There was a GP who was the practice GP registrar trainer. This meant the practice had an active role in the training of doctors specialising in general practice. GP registrars are doctors in the final stage of their training as a GP. They are fully qualified with at least 3 years postgraduate experience and are available for consultation.