The Croft Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

The Croft Surgery was a GP practice located in Kirkbride, Wigton. It served a rural community and was a dispensing practice. The practice registered with the Care Quality Commission (CQC) on 1 April 2013 to provide the following regulates activities:-

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

We spoke with a member of the Patient Participation Group (PPG) on the telephone prior to the day of the inspection visit. We also spoke with two patient trustees of the patient fund on the day of the inspection visit, and an additional four patients attending the surgery for appointments. The patients we spoke with were very complimentary about the service and we received excellent feedback from the comment cards which were left for patients to complete during our inspection.

We found managers and partner GPs had fostered an open and learning culture across the practice. The practice invested time supporting, training and ensuring the care provided was not just good, but consistent, enduring and safe.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the service was safe. Comments received from patients did not raise any concerns over patient safety.

The surgery learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of health acquired infection. The surgery managed medicines effectively.

Are services effective?

Overall the service was effective. Patients told us that they received good quality care from staff at the practice. We found care and treatment was delivered in line with recognised best practice standards and guidelines. We saw that staff carried out assessments which covered health care needs.

Staff were appropriately qualified and competent to carry out their roles safely and effectively. They had opportunities to develop their skills and practice.

The practice worked closely with other providers to co-ordinate care.

Are services caring?

Overall the service was caring. Feedback from patients about the practice was overwhelmingly positive.

We found staff were courteous and respectful. Patients were dealt with in a friendly and efficient manner.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Are services responsive to people's needs?

Overall the service was responsive. We found appointments were available to meet people's needs and individual preferences.

There were arrangements in place so patients whose first language was not English could access the service and communicate their needs.

There was a clear complaints policy and staff and patients were aware of how to make and respond to any complaints.

Summary of findings

Are services well-led?

Overall the service was well led. We found that partner GPs and managers had fostered an open and learning culture across the practice. There was a strong and visible leadership team, with a clear vision and purpose. Staff were committed to improving standards and were encouraged to have good working relationships amongst the staff and other stakeholders.

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

We found overall the service was safe, effective, caring, responsive and well led for older people.

There were effective arrangements in place to identify vulnerable and frail older people at risk of abuse. We found there was continuity of care for older people and patients were given information on sources of support, promotion of health lifestyles and prevention of ill health.

There were compassionate arrangements in place to support people at the end of their life.

We found that where patients did not have the capacity to consent, for example because their cognitive abilities had been significantly impaired due to the symptoms of dementia, the practice acted in accordance with legal requirements.

People with long-term conditions

We found overall the service was safe, effective, caring, responsive and well led for people with long term conditions.

There were safe arrangements in place to manage repeat prescriptions for people with long term conditions. We found the practice had arrangements in place to help patients manage their long term conditions. There were compassionate arrangements in place to support people at the end of their life. We found there was continuity of care for people with long term conditions.

Mothers, babies, children and young people

We found overall the service was safe, effective, caring, responsive and well led for mothers, babies, children and young people.

There were effective arrangements in place to safeguard children and young people. Mothers, babies, children and young people had continuity of care.

We found care and treatment was delivered in line with recognised best practice standards and guidelines. Expectant mothers and babies had medical support from midwives and health visitors, delivered in conjunction with the practice.

Summary of findings

The working-age population and those recently retired

We found overall the service was safe, effective, caring, responsive and well led for working age people. The practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Patients received advice and guidance about making healthy life style choices.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

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

We found overall the service was safe, effective, caring, responsive and well led for people who were in vulnerable circumstances who may have poor access to primary care.

There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse.

People received continuity of care.

Patients whose first language was not English were supported to access the service and communicate their needs. However there were no notices displayed in the reception or waiting area to let patients know this service was available. Arrangements were in place to meet patients' individual needs

People experiencing poor mental health

We found overall the service was safe, effective, caring, responsive and well led for people experiencing poor mental health. There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse. Patients experienced continuity of care. Where patients did not have the capacity to consent, the practice acted in accordance with legal requirements

Summary of findings

What people who use the service say

Patients who used the service told us that it met their healthcare needs. They told us that both clinical and non clinical staff treated them with respect, discussed their treatment choices and helped them to maintain their privacy and dignity. Patients told us that they would be happy to recommend the surgery to family and friends.

Patients told us they had no problems accessing appointments in an emergency. This was because the practice operated an open surgery each weekday morning, where they could turn up and be guaranteed to see a doctor or the practice nurse. This worked well for people with acute conditions. A booked appointment system was also available for those with longer term or chronic illnesses. Patients told us they liked this two tier system. They told us that when they booked an appointment, they normally got to see their preferred GP. Patients with long term conditions told us that they valued the continuity of care provided by the surgery.

Comment cards which had been left at the practice by CQC to enable people to record their views on the service were overwhelmingly positive and emphasised the standard and quality of care patients received.

Areas for improvement

Action the service COULD take to improve

- The practice could consider strengthening the process for managing controlled drugs to reduce the risk of theft or misuse.
- The practice could review the recruitment process to ensure that appropriate pre-employment checks were carried out and recorded prior to a staff member taking up post.

Good practice

Our inspection team highlighted the following areas of good practice:

- The Croft Surgery had developed its appointment system to fit the needs of the local population. It had an open surgery each morning, with booked appointments available throughout the day. There was evidence this was well liked by patients.
- The practice had in place arrangements to ensure access to shingles, flu and pneumovax vaccinations for the local community. This included flu clinics delivered from local community locations and home visit vaccinations for the housebound.
- The practice had developed information leaflets for patients to give advice and to help patients manage certain long term conditions.

The Croft SurgeryThe Croft Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a specialist adviser, who was a practice manager.

Background to The Croft Surgery

The Croft Surgery was situated in Cumbria close to the centre of village of Kirkbride. It sat within the locality district boundary of Allerdale. Due to the rural nature of the practice boundary, the practice also offered a dispensing service to patients.

The practice provided services for 3291 on the patient list. The service was provided to a diverse rural population. The local area had low levels of deprivation but an elderly population. The area the practice covered were Kirkbride, Newton Arlosh, Bowness on Solway, Port Carlisle, Anthorn, Glasson, Burgh-by-Sands, Drumburgh, Wigton Carlisle, Little Bampton, Moorhouse, Aikton, Kirkbampton and Thurstonfield. There was a very small percentage of the population whose first language was not English.

There were 13 full and part time staff, including 4 partner GPs. There were two practice nurses, two dispensers with another due to take up post imminently, an administration manager and a practice manager. Other healthcare professionals, such as district nurses, health visitors and midwives provided sessions or kept in regular contact with the Croft Surgery.

The Croft Surgery was open Monday to Friday 08:00 until 18:30. There was an open surgery which ran from 8:30 until 10:00, and booked appointments available from 8:30 until 17:50. Out of hours the surgery telephone service diverted patients to Cumbria Health on Call (CHOC) who assessed people's needs or alternatively in emergencies referred people to the 999 service for an ambulance.

The surgery reserved a small number of appointments each day for those people who needed an urgent appointment. This meant urgent cases could be seen on the day either through the open surgery or by a booked emergency appointment. Home visits could be carried out by the duty GP for those who were not well enough to attend the surgery.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

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

We carried out an announced visit on 6 May 2014.

During our visit we spoke with a range of staff including; some of the GP partners, the practice manager, administration manager, dispenser, practice nurse, secretaries and receptionists. We spoke with patients who used the service in the surgery and by telephone.

We talked with carers and/or family members. We looked at records kept by the practice. We held a listening event and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

Overall the service was safe. Comments received from patients did not raise any concerns over patient safety.

The practice learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of health acquired infection. The practice managed medicines effectively.

Our findings

Safe patient care

We spoke with seven patients, both in person on the day of the inspection and over the telephone, who were using the service. We read 28 CQC comment cards that had been completed by patients who used the service in the week before and on the day of our inspection. All the comments we received were positive and did not raise any concerns over patient safety.

Their comments included;

- "I have been asked about a chaperone in the past when I had a smear test."
- "The environment is safe and hygienic."
- "I've never had any concerns about the cleanliness of the surgery."

We found that the practice adopted a strong ethos of patient safety. We saw the practice had appropriate policies and procedures in place to support the identification of significant events and subsequent learning. The surgery had identified nine significant events over the previous year. We saw appropriate action had been taken to identify the significant events, identify the cause and subsequent learning.

These included some significant events where robust processes were already in place and had greatly reduced the risks for patients. For example, one of the identified incidents related to a safety alert made by the Medicines and Healthcare Products Regulatory Agency (MHRA) relating to a drug, a Novamix 30 Penfill. It related to batches of Novamix which needed to be recalled if they had been dispensed to patients. We saw this was checked and acted upon with no patient harm identified.

We saw that the GPs worked closely with the medicine dispensers to minimise errors. Any errors were recorded and reviewed. We saw three examples where although no harm had come to patients, the practice had identified learning and improvements to patient safety mechanisms.

Learning from incidents

The practice had in place arrangements for reporting significant events and incidents which occurred in the practice. We discussed the process with the lead GP and practice manager who showed us the records of these. We saw significant events were analysed to identify if there was

any learning for the practice. We saw evidence these were discussed regularly at team meetings, where appropriate. Where changes to processes or systems were identified as a result of the significant event, we saw systems were changed and signed off by the person who took ownership of this. For example, changes had been made to the process for checking medical test results when they came into the surgery.

Safeguarding

Patients all reported they felt safe using the services at The Croft Surgery. The patients we spoke with told us that they knew they could ask for a chaperone to ensure they stayed safe whilst being examined, but most reported they did not feel the need for this service. We saw information in the waiting areas informing patients of the chaperone policy. The practice manager told us that the practice nurses usually provided the chaperone service, however all staff who were willing to provide this service had received specific training.

One of the GP partners was the identified lead for the safeguarding of children, young people and vulnerable adults. This ensured that an identified lead was responsible for keeping policies and procedures up to date and updating staff within the practice. We looked at a sample of staff training records which showed staff had received safeguarding training. The staff we spoke with demonstrated an understanding of safeguarding patients from the risk of abuse. They knew what to do if they suspected anyone was at risk of harm. We saw that information about what to do if you suspected someone was being or at risk of being abused was displayed in staff areas. This included the contact details for other relevant agencies and organisations.

The practice manager told us that GPs attended safeguarding case conferences wherever it was appropriate and they were free to attend. Case conferences were multi-agency meetings which considered the steps needed to reduce or remove the risks for children, young people and vulnerable adults. Where GPs were unable to attend, they submitted case conference reports to inform this process.

Staff showed us how alerts were used on patient records to share information that clinical staff may need to know when treating someone. This included alerts that indicated a child was on the child protection register.

These measures meant the practice had arrangements in place so that abuse could be identified and to minimise the risk of abuse happening.

Monitoring safety and responding to risk

We saw evidence that no accidents had happened, such as trips, slips or falls within the surgery for a number of years. There was evidence that the surgery had a number of policies and procedures in place to identify and respond to areas of risk. This included regular fire tests and drills, maintenance of the building and equipment, and the training of staff in health and safety. We found all fire safety equipment, such as fire extinguishers, was maintained and service records were available.

Medicines management

We found that there were appropriate arrangements in place for managing medicines. Effective standard operating procedures were in place for all aspects of medicines handling. These were reviewed annually and accessible to staff. The quality of medicines management was monitored by a lead GP who fed back information to the practice. National safety alerts regarding medicines were acted on by the surgery.

The practice used the Dispensit IT system for medication stock management. All medications were logged onto the system when received, with their batch number and expiry date. We saw evidence these were checked monthly against the physical stock to ensure accuracy. Items were visibly tagged when they were nearing their expiry date. This ensured stocks of medicines were effectively managed. This eliminated the risks of dispensing out of date stock and helped maintain the 'first in first out' dispensing standard.

We checked storage of medicines, including emergency medicines and vaccines. We found these were kept safely, within an appropriate temperature range and stock was rotated. Arrangements were in place to manage controlled drugs (CD) safely. However, we saw only one signature was required to authorise a withdrawal from the CD stock. Two signatures to confirm a withdrawal is considered best practice because it reduces the risk of theft or misuse of controlled drugs.

We saw GPs initiated the repeat prescriptions for drugs with particular patient safety issues, where medication dosage needs to be checked against blood test results. This was to monitor the effectiveness or potential toxicity of drugs,

which have a narrow margin where they remain beneficial for patients. For example warfarin, used to stop blood clots. A patient taking too much warfarin had an increased risk of excessive bleeding, whereas not taking enough could cause blood clots. The monitoring systems in place increased the safety of prescribing and dispensing these medications.

Cleanliness and infection control

We found the practice had processes in place to maintain a clean environment and they had taken action to reduce the risk of the spread of infections. There were appropriate policies and procedures in place to support staff in maintaining a clean and hygienic environment and to reduce the risk of infection.

The patients we spoke with told us that they found the surgery and consultation rooms were kept clean. For example in a comment card we received, one patient said, "I feel it's a hygienic and safe environment."

We looked around the practice, general surgery areas, and treatment and consultation rooms. We found that these were clean, tidy and well maintained. There was a cleaning schedule in place, which set out when and how different parts of the building, fixtures, fittings and environment should be cleaned.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was impermeable, and easy to clean. We saw other areas, such as waiting area and doctors consulting rooms were fitted with carpet, which can be difficult to clean. It is best practice that all finishes in healthcare facilities should be chosen with cleaning in mind, especially where contamination with blood or bodily fluids is a possibility. However, we noted that flooring was clean, and was free from stains and odour.

Signs informing patients and staff of good hand washing techniques were displayed next to hand washing facilities.

Staffing and recruitment

The practice manager told us that they had recently looked at the staffing levels and skills mix within the practice. They had identified, that as a small team, succession planning was a priority. Therefore, it was planned that any new administration staff recruited, would be trained in both the administration and dispensary roles to provide flexibility and responsiveness as a staff team. The practice manager told us that they had a stable staff team, and people only tended to leave their employ to retire or leave the employment market entirely.

We looked at the recruitment records for two nurses, a dispenser and an administration staff member. We found that records of the recruitment process were variable. Schedule three of the Health and Social Care Act 2008 (Regulated Activities) sets out what information should be kept by the practice for any person seeking to carry on, manage or work for a provider delivering a regulated activity within health or social care. We found that the practice did not have in place all the information set out in this schedule for all members of staff.

All the staff files we looked at had either a Curriculum Vitea (CV) or an application form held on record. We saw that brief hand written notes had been made on these, detailing the views of referees. However, these did not clearly set out the evidence of previous conduct. There was no evidence that gaps in employment history or the reason why previous employment ended had been explored in any of the records we looked at. There was no evidence that proof of identity had been checked and there was not a recent photograph of the staff member retained on their file.

Some staff had been subject to a criminal records check (CRB), now known as a Disclosure and Barring Scheme (DBS) check. This check identified whether a person had been convicted of any criminal offences, to enable the practice to determine whether the person was suitable for the job role. However there was no risk assessment in place which stated which staff needed to be subject to a check of this kind and which did not. There was no consistency across the files we looked at. One nurse had been subject to a check, whilst the other had not. The administration worker had been subject to a check, whilst the dispenser had not. We discussed this with a partner GP and the practice manager during the inspection visit. They told us the original CRB checks had been made in conjunction with the previous Primary Care Trust (PCT). They had sought advice and guidance from the PCT at the time as to who should be subject to a check. However they had not revisited this since. They said they would look at how they could ensure consistency in obtaining a DBS check for staff members.

Are services safe?

The practice had checked that where staff were required to register with a relevant professional body to practice, that this registration was maintained. For example, registration with the Nursing and Midwifery Council (NMC) was checked annually for nurses.

The practice was undertaking pre-employment checks to ensure that staff were suitable for the role they were being employed to undertake. However the robustness of the checks undertaken and the quality of recording was variable.

Dealing with Emergencies

There were robust plans in place to deal with emergencies that might interrupt the smooth running of the service. Alternative sites had been identified for potential use if the surgery became unavailable for any reason. Risks to providing services because of failure of power and utilities had been considered, as had interruption of access to both clinical and paper records. The practice manager told us that they had not yet had to use the plan in full. Some areas within the practice boundary were subject to flooding. The practice manager told us they kept an eye on tide times to inform the safest time for GPs to carry out home visits.

Staff told us and we saw from training records, they had received first aid and cardiopulmonary resuscitation (CPR) training. Reception staff gave us an example of an emergency situation, where a patient collapsed in the reception area and a GP was immediately called upon to give medical assistance.

Equipment

We saw records to demonstrate that equipment was well maintained and serviced regularly. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines.

The practice had resuscitation equipment and medication available for managing medical emergencies. We saw all items, including oxygen kits and drugs were within expiry date and regular equipment checks were undertaken. The defibrillator equipment was checked and correctly functioning, the defibrillator pads were in date and the logbook of checks was also up-to-date and appropriately signed.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective. Patients told us that they received good quality care from staff at the practice. We found care and treatment was delivered in line with recognised best practice standards and guidelines. We saw that staff carried out assessments which covered health care needs.

Staff were appropriately qualified and competent to carry out their roles safely and effectively. They had opportunities to develop their skills and practice.

The practice worked closely with other providers to co-ordinate care.

Our findings

Promoting best practice

We found care and treatment was delivered in line with recognised best practice standards and guidelines. We saw that staff carried out assessments of patients which covered their health care needs.

We spoke with the practice nurse about the how they helped people with long term conditions manage their health. They told us that they booked people in for recall appointments at a date and time that was convenient for the patient. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition. At the time of the inspection the practice had a manual recall system in place, but was in the process of automating this. This would allow them to match up patients with multiple long term conditions, so one review could cover their needs, rather than separate reviews for each condition.

The practice had developed information on the management of type I and type II diabetes, particularly in relation to the use of insulin when the patient was unwell. They had also developed a leaflet on the use of ACE inhibitors, specific to the needs of patients of the practice. ACE inhibitors (or angiotensin-converting-enzyme inhibitor) are a pharmaceutical drug used primarily for the treatment of hypertension (elevated blood pressure) and congestive heart failure (CHF).

One patient commented on a CQC comment card, “Following heart surgery, the care for my INR has been regular.” INR or international normalized ratio blood level is a measurement to determine the effects of oral anticoagulants on the clotting system.

Therefore we found the practice had arrangements in place to help patients manage their long term conditions.

Management, monitoring and improving outcomes for people

We saw the practice operated a clinical audit system which continually improved the service and provided the best possible outcomes for patients. We found delivery of care and treatment achieved positive outcomes for people.

Are services effective?

(for example, treatment is effective)

The practice had invited the Medical Protection Society (MPS) to undertake a clinical risk management assessment. This had included assistance for the practice to develop protocols to use in chaperone training and in relation to issues of consent.

Staffing

Staff were appropriately qualified and competent to carry out their roles safely and effectively. There was an induction pack for new staff. Staff had opportunities for professional development beyond mandatory training. One of the nurses told us, "The doctors here are keen to develop the skills of staff. They are keen to do education sessions. I've never been turned down when I have asked to do courses in the past. I've been on a few courses recently to up skill. In particular we have been building up knowledge in respiratory care." They also told us, "I feel like I get the professional support I need."

The practice had recently started to use the Blue Stream e learning system to provide access to mandatory training. This had helped to identify individual learning needs and had proved popular with staff. The practice also had protected learning time, which was used as dedicated time to brief and train staff. We saw training sessions staff had attended or were due to undertake were monitored to ensure staff had the knowledge and skills required to undertake their work.

Staff told us and we saw evidence that they had regular appraisal. We found these were up to date.

These measures meant that patients received care and treatment from staff who were suitably supported, trained and qualified to undertake their role.

There were arrangements in place for staff to provide cover during holiday periods and in the event of sickness absence. The two nurses covered each other's absences, as did the reception staff. Staff worked on a rota basis to ensure all core hours were covered. A staff member told us, "I feel supported. Yes definitely. We are a close team – we see each other outside of work. There is always a hand over of work with everyone in the team."

These measures ensured there were enough staff during surgery hours, with handover arrangements, to deliver a good standard of care.

Working with other services

We found the practice had effective processes in place for the referral of patients to secondary care such as the local hospital. We discussed the process and timescales for referring people to secondary care with a partner GP. They showed us evidence that referrals were appropriate and made in a timely way. For example, the time taken for patients to be referred to cancer specialists was within best practice guidelines. This was also supported by the low numbers of patients admitted to accident and emergency departments from the practice group, with a first diagnosis of cancer. This indicated a high standard of care in primary care settings. Most referrals were made within a consultation with the GP, with options discussed and an appointment booked at the same time. The exception to this would be where it was necessary to contact the local commissioning teams in the Clinical Commissioning Group (CCG) for approval, for very specialist services.

We spoke with the practice receptionist in relation to their duties in referral management. They told us they liaised with the CCG, which was responsible for commissioning secondary healthcare. They told us they attended a referral management meeting with the CCG every two months to look at referral processes and patterns. Every fourth meeting a partner GP also attended. This helped share best practice across GP surgeries within the area.

Analysis and audit of the referrals process was supported within the practice with a piece of software called 'RADAR'. Staff told us there were a comparatively low number of referrals made by the practice. They thought this was because as a patient group, patients tended to self-manage and were historically not big users of hospital and community services within the area due to the rural nature of the practice boundary.

One patient shared with us their experiences of referral to secondary care. They said, "It's not always been a smooth pathway, but not the fault of the surgery – cardiology mix up. The practice has chased this up on my behalf."

Other healthcare professionals, such as health visitors and midwives provided sessions within the surgery. There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses, health visitors and midwives.

Are services effective?

(for example, treatment is effective)

Health, promotion and prevention

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health. Test kits for chlamydia were available for young people under the age of 25 to pick up. This supported good sexual health awareness for this population group.

The practice offered smoking cessation sessions. However, the practice was identified as an outlier on smoking cessation advice on the General Practice Outcome Standards (GPOS). GPOS were developed by clinicians in collaboration with the London wide Local Medical Committees (LMCs), NHS London, and Commissioners as an agreed approach to improve quality. The practice was unable to give a reason why they were an outlier for this indicator, but thought it could be due to a recording issue.

We looked at the new patient registration process. We found the new registration forms had additional questions about social needs and people who were at risk of abuse. This was followed up by the GP as part of the new patient check.

Two patients told us how the practice supported health promotion and awareness. One patient said, "[The doctors] will tactfully explore whether social factors, such as drinking alcohol or smoking could be the reason for ill health. They do this in a non-judgmental way. It's something they have to do."

Another patient said, "I have a family history of heart conditions – they give guidance as to what treatments and medication – there is an understanding with the GPs that people may not want to go down that route, but they gently persuade what is best for you and I trust them."

Patients received advice and guidance about making healthy life style choices.

Are services caring?

Summary of findings

Overall the service was caring. Feedback from patients about the practice was overwhelmingly positive.

We found staff were courteous and respectful. Patients were dealt with in a friendly, but efficient manner.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Our findings

Respect, dignity, compassion and empathy

Patients told us that they received good quality care from staff at the practice. This was supported by all of the 28 CQC comment cards which noted a high quality of care delivered by the practice.

Comments included, "Absolutely brilliant, the service is really good and they make you feel you count"; "Kirkbride (The Croft) Surgery is the best I have known in my whole life. No nonsense professionalism with a happy face is wonderful "; and, "Kirkbride (The Croft) Surgery should be used as a model against which others are judged." A number of the comment cards noted particular staff who patients felt deserved additional praise. These included reception and administration staff, practice nurses and GPs.

All seven patients we spoke with said that they were treated with dignity and respect by staff at the Croft Surgery. Comments included, "I am always treated with dignity and respect. The reception staff are very polite and accommodating. GP has my best interests and I am not on my own in thinking this – think we are very lucky to have these GPs looking after us."; "Absolutely, Reception staff are courteous, polite and recognise me. I am here a lot. I've had bloods done this morning and they allow me to come in after closure so that I don't have to sit and wait with ill people, as I have a low immune system. This is very considerate of the Practice"; and, "Receptionists have been so exceptionally caring. Felt very cared for as well as my partner cared for."

People who completed CQC comment cards also noted how caring staff were. Comments included:

- "Staff are fantastic and always very helpful. They are compassionate. Very empathetic."
- "Staff have always been caring, without fail. Have always listened and worked hard to make appointments and get prescriptions expeditiously."
- "I have received constant care through the past 13 years at this surgery and have always been treated with care and respect."

The national GP survey (01/01/2013 – 30/09/2013) also demonstrated good levels of patient satisfaction, with performance either similar or better than other local practices. This included indicators such as; were patients able to contact the surgery easily; whether clinical staff

explained things to patients in a satisfactory way; and the convenience of appointments. We observed interactions between reception staff and patients. We found staff were courteous and respectful. Patients were dealt with in a friendly and efficient manner.

We spoke with a partner GP about coordination and integration of care, in particular in relation to patients reaching the end of their life. The GP told us they made sure that patients experienced integrated care by recording notes about their care and treatment needs and by sharing this with the Cumbria Health on Call (CHOC) out of hours provider. This ensured continuity of care. They discussed with the patients their views and wishes on how they wanted to be supported in their final moments. This included the early provision of drugs that it could be anticipated patients would need, to manage pain and other symptoms of illness, prior to death. Also the preferred place of care, for example whether this was in a hospice or at home. The practice liaised closely with the district nursing service to ensure people's needs were met during this time. There were compassionate arrangements in place to support people at the end of their life.

We saw a number of leaflets were available in the reception area to signpost people receiving end of life care, their families and loved ones or the recently bereaved to sources of support. This included Cruse Bereavement Service, local hospices and the Cancer Patient and Carer Advisory Panel.

Involvement in decisions and consent

We spoke with seven patients about their involvement in making decisions and consenting to care and treatment. They told us that GPs and nurses took the time to explain things to them to enable them to make their own decisions. Comments included:

- "This is always explained to me. It happened this morning as GP wanted to add in another medication and suggested trying this new medication short term. This was explained to me before I agreed."
- "I came in to speak to the doctor about whether I should have a flu jab, as I wasn't sure. The doctor explained very clearly why it was a good idea. The doctor will draw you diagrams to help you understand the information they are giving you. They will go through everything in detail."
- "Not had a procedure without having had a discussion."

Before the inspection CQC comment cards were left in the reception waiting rooms. We received 28 responses. Comments included:

- "Always have everything explained and never left feeling I had more questions."
- "The doctor gave excellent advice."
- "I feel respected and that my reasons for consulting are important and worthy of time and attention. Nothing is too much trouble."

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

We discussed with a partner GP the action they took when a patient was assessed as lacking capacity to make a decision. They gave us examples where they had made 'best interest' decisions on behalf of patients. The Mental Capacity Act (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

We discussed examples of where they had acted in best interests of patients. They told us about a patient who had advanced dementia and a lack of cognitive ability who wished to continue driving. They told us about the process they went through to make sure the decision was in the best interest of the patient. We also discussed a number of scenarios with the GP in relation to living wills, patients lacking capacity, and those patients who had opted out of the national NHS Summary Care Records programme. The practice protocols within these scenarios were discussed. The measures in place demonstrated that where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive. We found appointments were available to meet people's needs and individual preferences.

There were arrangements in place so patients whose first language was not English could access the service and communicate their needs.

There was a clear complaints policy and staff and patients were aware of how to make and respond to any complaints.

Our findings

Responding to and meeting people's needs

The practice was accessible to patients with mobility difficulties. The practice was a single story building, and therefore all treatment and consultation rooms were on the ground floor. There was some parking directly outside the practice for those with mobility difficulties, and plenty of free parking on the surrounding streets.

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service. This meant patients whose first language was not English were supported to access the service and communicate their needs. However, there was no information displayed in patient areas, which told people this service was available, in the most common languages.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail or had a learning disability, this was noted on the medical system. This meant the GP or nurse were aware of this information prior to an appointment, so they could plan and offer additional support as needed. For example, a longer appointment time or to escort the patient from the waiting area to the consultation or treatment rooms.

We saw a sign in reception which stated "if you have a difficulty hearing, would like to speak to a receptionist in private or need any assistance please ask us and we will help you." These measures meant arrangements were in place to meet patient's individual needs.

Patients told us that flu clinics delivered by the surgery in local community outreach centres were popular. This ensured a greater access to flu vaccination for the local community. They told us that these events often turned out to be very social, with teas and coffees offered to patients. This offered more convenient locations for people living within the rural community, and increased access for those who do not have their own transport or would find it difficult to travel to the surgery itself.

People told us they could normally see the GP of their choice.

We spoke with staff about the processes for repeat prescriptions. They told us that requests could be made in

Are services responsive to people's needs?

(for example, to feedback?)

person, via the telephone or via the internet. The patients we spoke with confirmed that this arrangement worked well, and that they were satisfied with the repeat prescription system.

The practice had benefited from generous donations from many patients over the years and had managed to acquire significant pieces of clinical equipment for use in patient care. This had included a split lamp for ophthalmic investigations, bladder scanner and defibrillator oxygen kits for every GP. These had reduced unnecessary referrals in both ophthalmology and urology. The GPs had audited the rate of referrals; we saw the results confirmed these benefits.

The practice had carried out an analysis of patients who had attended the local Accident and Emergency Department (A&E) from the practice area, based on post codes. This showed that few patients within the practice boundary attended at A&E rather than the practice itself. There was a pattern of patients who were closer to Carlisle who had attended at A&E in Carlisle infirmary. However, the analysis did not indicate that people were repeat visitors to A&E unnecessarily. The practice routinely sent out letters to people who used A&E inappropriately with the leaflet 'Doctor first'. Staff thought that the morning open surgery helped with the low numbers in the area accessing A&E services unnecessarily. This meant the practice was supporting patients to make appropriate decisions about which healthcare services to access and when.

Access to the service

The Croft Surgery was open from 8am until 6:30pm. It offered an open surgery from 8:30 until 10am. Staff gave examples where the surgery had stayed open until all patients had been seen. They told us if patients came in during the open surgery hours, they would guarantee they would see a doctor or nurse. A partner GP told us that the system worked well, as people only used the time they needed to see the doctor, and there were no gaps because patients failed to turn up. He told us that he felt the open surgery was an efficient way of seeing a lot of patients.

Booked appointments were available at other times between 8:30 and 17:50. The surgery reserved a small number of appointments each day for those people who need an urgent appointment. This meant urgent cases could be seen on the day either through the open surgery or by a booked emergency appointment. Home visits were carried out by the duty GP for those who were not well enough to attend the surgery.

We found appointments were available to meet people's needs and individual preferences.

The patients we spoke with confirmed they liked the appointment system within the surgery. Comments included, "Open surgery suits me fine, but if I need an appointment, one is always provided. They keep making changes to try to make it work best for patients. Both systems suit me fine."; "I try to keep my appointment in the open surgery fairly brief but longer if for a booked one – both systems work well for me"; and, "Open surgery is brilliant. That's how I got through this last year." People told us that staff tried to meet their needs. For example, "I prefer to make an appointment, but I was seeing nurse today so asked to see a GP as well and was accommodated." And "Even before this problem with my partner, they were great, but since this problem, they have been exceptional – they go the extra mile with everything."

We found the practice had an up to date leaflet, which provided information about the surgery and the services provided. It also included contact details for the surgery, information on how to register with the service and how to request repeat prescriptions. This demonstrated patients were provided with information on how to access services.

Concerns and complaints

The practice had a robust protocol for dealing with complaints which demonstrated a responsive approach. However, we saw complaints were very rare. The practice had received no complaints over the last year, and only two complaints had been registered in the last five years. Both of these complaints were minor and were dealt with appropriately.

The practice had just put in place a customer suggestions box. Two comments had been received and the practice were still in the process of looking at how they could act on these.

As part of the appraisal process for each GP in the five year revalidation cycle, individual GPs undertook a patient satisfaction survey. The practice shared the results of these with us. Feedback from patients was very positive.

Are services responsive to people's needs?

(for example, to feedback?)

Therefore we found people had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint. Also people's complaints were fully investigated and resolved, where possible, to their satisfaction.

Are services well-led?

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

Summary of findings

Overall the service was well led. We found that partner GPs and managers had fostered an open and learning culture across the practice. There was a strong and visible leadership team, with a clear vision and purpose. Staff were committed to improving standards and were encouraged to have good working relationships amongst themselves and other stakeholders.

Our findings

Leadership and culture

There was a well-established management structure with clear allocations of responsibilities. Each of the doctors had leadership roles, for example medicines management, safeguarding and infection control. A GP partner told us that the practice had always tried to have a development strategy and vision. The senior partner had developed a month by month strategic planning tool and each month the practice focused on carrying out particular tasks. In the longer term the practice planned to become a training practice for GP registrars.

We found that partner GPs and managers had fostered an open and learning culture across the practice.

The staff we spoke with talked positively about the practice. Comments included, "I enjoy and look forward to coming to work, patients are lovely and nice people to work with" and "I like it here, otherwise I wouldn't have worked here so long if I didn't. There have been a lot of changes over the years, but we always try and do what is best for local people."

Governance arrangements

We found the practice had a positive approach to governance and leadership. There were three meetings on a cyclical basis, which integrated and enhanced practice performance. These were a primary healthcare team meeting, at which significant event analysis, safeguarding children and vulnerable adult specific issues, palliative care, other important clinical issues and other issues raised by the team were discussed. A business meeting, with the practice manager and partners as well as a contract meeting where local enhanced services and referrals processes were discussed.

Systems to monitor and improve quality and improvement

We saw records of audits and checks carried out to make sure the practice delivered high quality patient care. These included checks of patient referrals, the environment, health and safety, and medication. We found the practice proactively evaluated the services provided to continually improve the quality of service.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) and a patient fund administered by patients

Are services well-led?

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

themselves, on behalf of the practice. The practice had benefited from generous donations from many patients over the years and had managed to acquire significant pieces of clinical equipment for use in patient care.

We spoke with three patients who were involved in either the PPG or the patient fund. They told us that the practice was open to listening to the views of patients. They told us how the practice had used the PPG as a sounding board when implementing new policies. An example of this was the requirement for all patients over the age of 75 to have a named doctor. The surgery had discussed with the PPG how this could be best implemented for the local population. For example, based on a geographic area or the doctor the patient saw most frequently. We looked at the last two notes of the PPG. We found that the practice encouraged the active participation of patients in making decisions about how services are delivered and any proposed changes.

The patients we spoke with were aware of the PPG, but not everyone understood its purpose. There was information displayed in the reception waiting area about the PPG and the Patient fund.

All patients we spoke with said they would recommend the Croft Surgery to family and friends. Comments included, "I would advise friends and family to come here – yes without a doubt – friendly, efficient – Receptionists who are lovely" and "I would recommend this practice to friends and family and I am happy with the service provided."

Staff engagement and involvement

The staff we spoke with during the inspection told us that they could raise suggestions or concerns with managers and GP partners. For example, staff told us, "We have the chance to make suggestions. They are always welcome. We have an opportunity to have input into how the practice is run" and "If we have any problems or concerns, I wouldn't have a concern approaching management or the GPs. Everyone helps each other."

Staff told us that the practice and administration managers worked well together. They said they saw each other all of the time, and if there was a problem then it was discussed and resolved quickly.

We saw that regular staff meetings were held. However they were not always formally minuted and staff told us these were normally held out of work hours and were ad hoc rather than planned.

These measures demonstrated that there was an open and learning culture within the practice. Staff were encouraged to make suggestions and their views were taken into account.

Learning and improvement

All the staff we spoke with demonstrated a clear understanding of their area of responsibility. Each person took an active role in ensuring that a high quality service was provided. There was a range of mandatory training that staff needed to complete. This was complemented by other training that staff felt would be useful in carrying out their roles.

Identification and management of risk

There were no formal risk assessments in place to ensure the health and safety of patients, visitors and staff members. The practice manager told us they were fairly new into post and the development of risk assessment was planned within the surgery.

Older people

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for older people.

There were effective arrangements in place to identify vulnerable and frail older people at risk of abuse. We found there was continuity of care for older people and patients were given information on sources of support, promotion of health lifestyles and prevention of ill health.

There were compassionate arrangements in place to support people at the end of their life.

We found that where patients did not have the capacity to consent, for example because their cognitive abilities had been significantly impaired due to the symptoms of dementia, the practice acted in accordance with legal requirements.

Our findings

Safe

The practice adopted a strong ethos of patient safety. There were effective arrangements in place to identify vulnerable and frail older people at risk of abuse.

Any specific individual needs, such as communication or mobility needs, were noted on the medical records to ensure staff were aware when additional support was required. This meant the risk of isolation from the service provided by the Croft Surgery was reduced.

We saw evidence that no accidents had happened, such as trips, slips or falls, within the surgery for a number of years. Older people who are frail or have mobility problems would be at particular risk of falls.

Effective

We found care and treatment was delivered in line with recognised best practice standards and guidelines.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. This ensured continuity of care for patients.

We saw there were a number of leaflets displayed in the waiting area for patients to access. This included information particularly relevant to older people. There was a folder of information from Age UK, which signposted people to sources of support and assistance. Patients were given information on sources of support, promotion of health lifestyles and prevention of ill health.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012/2013. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. This showed that the practice maintained a register of people diagnosed with dementia and the needs of those on the register were reviewed regularly.

Older people

People aged over 80 were sent an annual birthday card, offering them a health check. This meant as people grew older they were supported to stay as healthy and well as possible.

Caring

We spoke with a patient within this age group. They told us they valued the service provided by the Croft Surgery. They told us the practice went out of their way to provide good quality care.

There were compassionate arrangements in place to support people at the end of their life.

We found that where people did not have the capacity to consent, for example because their cognitive abilities had been impaired due to the symptoms of dementia, the Practice acted in accordance with legal requirements.

Responsive

We found appointments were available to meet people's needs and individual preferences.

We saw there were arrangements in place to meet the specific needs for those patients who needed additional support. For example, with communication or mobility needs.

The practice had in place arrangements to ensure access to shingles, flu and pneumovax vaccinations for the local community. This included flu clinics delivered from local community locations and home visit vaccinations for the housebound.

There was an active Patient Participation Group (PPG). Members of this group told us that they had recently discussed the requirement for all people over the age of 75 to have a named GP. The surgery had discussed with the PPG how this could be best implemented for the local population. For example, based on a geographic area or the doctor the patient saw most frequently. We found that The Croft Surgery encouraged the active participation of patients in making decisions about how services were delivered and any proposed changes.

Well led

We found that partner GPs and managers had fostered an open and learning culture across the practice.

People with long term conditions

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for people with long term conditions.

There were safe arrangements in place to manage repeat prescriptions for people with long term conditions. We found the practice had arrangements in place to help patients manage their long term conditions. There were compassionate arrangements in place to support people at the end of their life. We found there was continuity of care for people with long term conditions.

Our findings

Safe

The practice adopted a strong ethos of patient safety.

There were safe arrangements in place to manage repeat prescriptions for people with long term conditions. This included where medication dosage needed to be checked against blood test results to monitor the effectiveness or potential toxicity of drugs, which have a narrow margin where they remain beneficial for patients. For example warfarin, used to stop blood clots, needed to be monitored in this way. A patient taking too much warfarin had an increased risk of excessive bleeding, whereas not taking enough could cause blood clots. The monitoring systems in place increased the safety of prescribing and dispensing these medications.

Effective

We found care and treatment was delivered in line with recognised best practice standards and guidelines.

We spoke with the practice nurse about how they helped people with long term conditions manage their health. They told us that they booked people in for recall appointments at a date and time that was convenient for the patient. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition. At the time of the inspection the practice had a manual recall system in place, but were in the process of changing this to an automated system. This would allow them to identify patients with multiple long term conditions, so one review could cover their needs, rather than separate reviews for each long term condition.

The practice had developed information on the management of type I and type II diabetes, particularly in relation to the use of insulin when the patient was unwell. They had also developed a leaflet on the use of ACE inhibitors, specific to the needs of patients of the practice.

People with long term conditions

ACE inhibitors (or angiotensin-converting-enzyme inhibitor) are a pharmaceutical drug used primarily for the treatment of hypertension (elevated blood pressure) and congestive heart failure (CHF).

One patient commented on a CQC comment card, "Following heart surgery, the care for my INR has been regular." INR or international normalized ratio blood level is a measurement to determine the effects of oral anticoagulants on the clotting system.

Therefore we found the practice had arrangements in place to help patients manage their long term conditions.

There were effective arrangements in place to monitor the effectiveness of referrals to secondary health care, such as medical specialists and consultants.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. This ensured continuity of care for patients with long term conditions.

Caring

Feedback from patients about the practice was overwhelmingly positive. This included feedback from patients with long term conditions.

There were compassionate arrangements in place to support people at the end of their life.

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Responsive

We found appointments were available to meet people's needs and individual preferences.

We saw there were arrangements in place to meet the specific needs for those patients who needed additional support. For example, with communication or mobility needs.

The practice had in place arrangements to ensure access to shingles, flu and pneumovax vaccinations for the local community. This included flu clinics delivered from local community locations and home visit vaccinations for the housebound.

The patients we spoke with who told us they had long term conditions said they normally saw a doctor of their choice. They told us this offered them greater continuity of care.

Well led

We found that partner GPs and managers had fostered an open and learning culture across the practice.

Mothers, babies, children and young people

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for mothers, babies, children and young people.

There were effective arrangements in place to safeguard children and young people. Mothers, babies, children and young people had continuity of care.

We found care and treatment was delivered in line with recognised best practice standards and guidelines. Expectant mothers and babies had medical support from midwives and health visitors, delivered in conjunction with the practice.

Our findings

Safe

The practice adopted a strong ethos of patient safety.

There were effective arrangements in place to safeguard children and young people. Indicators that children and young people were at risk of abuse were considered as part of the new patient registration process. Therefore the practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Doctors had been trained in spotting and dealing with issues relating to domestic violence, safeguarding and genital mutilation.

The practice manager told us that GPs attended safeguarding case conferences wherever it was appropriate and they were free to attend. These are multi-agency meetings which consider the steps that are needed to reduce or remove the risks for children, young people and vulnerable adults at risk of abuse. Where GPs were unable to attend, they submitted case conference reports to inform this process.

Staff showed us how alerts were used on patient records to share information clinical staff may need to know when treating someone to keep them safe. This included alerts where children were on the child protection register.

Staff told us that all looked after children were also coded on their medical records. This provided clinical staff with information they needed to meet the needs of children in care and on the child protection register, to ensure that health outcomes matched those of other children.

The practice told us they had arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people. This included child protection officers, health visitors, midwifes, school nurses and children and adolescent mental health workers. This ensured continuity of care.

Mothers, babies, children and young people

Effective
We found care and treatment was delivered in line with recognised best practice standards and guidelines.

The practice told us that following the birth of a child, routine home visits were made to check on progress and offer support to mother and child. A six week post-natal check was also carried out. This ensured the health needs of both child and mother were considered at an early stage. All new babies were invited for a check-up and offered immunisations in conjunction with the health visitor.

Caring
We saw there were toys available within the reception waiting area. We saw evidence these were cleaned regularly. This created a homely, friendlier environment for children visiting the surgery.

Responsive
We found appointments were available to meet people's needs and individual preferences.

Expectant mothers and babies had medical support from midwives and health visitors, delivered in conjunction with the practice. An antenatal clinic was held each Tuesday morning in the surgery.

Well led
We found that partner GPs and managers had fostered an open and learning culture across the practice.

Working age people (and those recently retired)

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for working age people. The practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Patients received advice and guidance about making healthy life style choices.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

Our findings

Safe

The practice adopted a strong ethos of patient safety.

Indicators that adults were at risk of abuse were considered as part of the new patient registration process. Therefore the practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Doctors had been trained in spotting and dealing with issues relating to domestic violence, safeguarding and genital mutilation.

Effective

We found care and treatment was delivered in line with recognised best practice standards and guidelines.

Test kits for chlamydia were available for young people under the age of 25. This supported good sexual health awareness for this population.

The new patient registration process considered social factors, such as smoking and drinking alcohol. Advice was given as part of this process about reducing the risks associated with social lifestyle choices. We saw that a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of health lifestyles, and prevention of ill health. Patients received advice and guidance about making healthy life style choices.

We found the practice had effective processes in place for the referral of patients to secondary care.

Caring

Feedback from patients about the practice was overwhelmingly positive. We found staff were courteous and respectful. Patients were dealt with in a friendly, but efficient manner.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

Working age people (and those recently retired)

Responsive

We found appointments were available to meet people's needs and individual preferences. There were appointments available out of normal working hours, at the start and end of the surgery sessions. There was also an open surgery in the morning. The patients we spoke with told us that the two types of appointment system worked well.

The surgery had not received any complaints or concerns over the proceeding twelve months. Patients we spoke with told us they had not had any concerns about the service, and had not had to make a complaint. This indicated that people were satisfied with the care and treatment they had received.

Well led

We found that partner GPs and managers had fostered an open and learning culture across the practice.

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

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for people who were in vulnerable circumstances who may have poor access to primary care.

There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse.

People received continuity of care.

Patients whose first language was not English were supported to access the service and communicate their needs. However there were no notices displayed in the reception or waiting area to let patients know this service was available. Arrangements were in place to meet patients' individual needs.

Our findings

Safe

The practice adopted a strong ethos of patient safety. There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse.

Indicators that adults were at risk of abuse were considered as part of the new patient registration process. Therefore the practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Doctors had been trained in spotting and dealing with issues relating to domestic violence, safeguarding and genital mutilation.

Effective

We found care and treatment was delivered in line with recognised best practice standards and guidelines.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses, health visitors and midwives. This ensured continuity of care.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. This demonstrated the practice could produce a register of patients aged 18 years and over with learning disabilities.

Caring

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service. This meant patients whose first language was not English were supported to access the service and communicate their needs. However, there was no information displayed in patient areas, which told people this service was available, in the most common languages.

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

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail or had a learning disability, this was noted on the medical system. This meant the GP or nurse would be aware of this information prior to an appointment, so they could plan and offer additional support as needed. For example, a longer appointment time or to escort the patient from the waiting area to the consultation or treatment rooms.

We saw a sign in reception which states “if you have a difficulty hearing, would like to speak to a receptionist in private or need any assistance please ask us and we will help you.” These measures meant arrangements were in place to meet patients' individual needs.

Responsive

We found appointments were available to meet people’s needs and individual preferences.

Well led

We found that partner GPs and managers had fostered an open and learning culture across the practice.

People experiencing poor mental health

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

Summary of findings

We found overall the service was safe, effective, caring, responsive and well led for people experiencing poor mental health. There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse. Patients experienced continuity of care. Where patients did not have the capacity to consent, the practice acted in accordance with legal requirements.

Our findings

Safe

The practice adopted a strong ethos of patient safety.

There were effective arrangements in place to identify people in vulnerable circumstances at risk of abuse.

Indicators that adults were at risk of abuse were considered as part of the new patient registration process. Therefore the practice had in place arrangements to identify abuse and reduce the risk of abuse happening. Doctors had been trained in spotting and dealing with issues relating to domestic violence, safeguarding and genital mutilation.

Effective

We found care and treatment was delivered in line with recognised best practice standards and guidelines.

There were arrangements in place to ensure the flow of information between the practice and other health and social care professionals, such as children and adolescent mental health teams, community mental health teams, crisis teams, forensic psychiatry and social services. This ensured continuity of care.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. The practice could produce a register of patients with schizophrenia, bipolar affective disorder and other psychoses. The practice was above the average for other local surgeries and the England average for assessing the impact of social factors, such as weight and alcohol consumption for this group of people. This meant the practice identified those at risk of experiencing poor mental health and reviewed the social factors that can impact on general health. However they were lower in indicators relating to monitoring this groups' medical need, such as recording if lithium levels were in the therapeutic range and recording of cholesterol levels. A high number of people experiencing poor mental health had a care plan in

People experiencing poor mental health

place to set out how their needs would be met. This meant the practice planned how they would meet the needs of people experiencing poor mental health, to ensure they could meet their needs.

Caring

We discussed with a partner GP the action they took when a patient was assessed as lacking capacity to make a decision. They gave us examples where they had made 'best interest' decisions on behalf of patients. The Mental Capacity Act (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

We discussed examples of where they had acted in best interests of patients. The measure in place demonstrated that where people did not have the capacity to consent, the practice acted in accordance with legal requirements.

Responsive

We found appointments were available to meet people's needs and individual preferences.

One patient told us how supportive the practice had been when their partner experienced a mental health crisis. They told us, "Even before this problem with my partner, they were great, but since this problem, they have been exceptional – they go the extra mile with everything."

We asked the practice about access to secondary care for patients experiencing poor mental health. They told us that they made immediate referral to the local mental health crisis team where patients presented with symptoms indicating an acute mental health episode. They said support by the crisis team was given quickly.

For other patients experiencing poor mental health, where the need for support was less urgent, there was a single point of contact to refer patients for support from specialist mental health services. However, the practice told us that following an initial assessment, it could take two to three weeks for patients to be allocated a worker and an appointment time. They told us they could access specialist advice from the Brookside Community Mental Health Centre to assist them in meeting patients' needs. However, they told us that it was difficult to speak with psychiatrists from this service, even when they were phoning for advice over the telephone. There were appropriate arrangements to refer patients for support from specialist mental health services.

Well led

We found that partner GPs and managers had fostered an open and learning culture across the practice.