Church Lane Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Church Lane Medical Centre on 4 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services and for being well led. It was also good for providing services for the older people and families, children and younger people.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- People told us they were treated with professionalism and respect, and that the practice responded well to patients that were visiting the area for patient care and support.
- Incidents and complaints were appropriately investigated and responded to.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had an effective governance system in place, was well organised and actively sought to learn from performance data, complaints, incidents and feedback.
- The practice showed a patient centred approach to delivering care and treatment.

The practice was proactive in improving health and access to services and engaged with other health and social care agencies to improve access and patients health.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing the capacity of patients and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. The practice had developed good supervision and support for all staff which included weekly and monthly reviews with the manager. Staff worked effectively with multidisciplinary teams and agencies.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally found it easy to make an appointment. However, some patients commented they found arranging an appointment could be challenging at times. Urgent appointments were available the same day. The practice had a range of facilities

Summary of findings

and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular staff meetings. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice promoted a two minute patient survey including friends and family test which patients were encouraged to complete on attendance at the practice. The patient participation group (PPG) was currently being re-established. Staff had received inductions, had regular performance reviews and attended staff meetings and training events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. There were a number of care homes in the practice area and all patients 75+ have a named GP. GPs made regular visits to patients in the care homes to provide care & support. Protected time was allocated to the GP to ensure continuity of care was delivered consistently and in line with older patient's needs. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and regular reviews took place for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients in this group had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP and or specialist nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care. The staff had received appropriate training in the management of long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours when it was convenient for children and teenagers to attend the surgery.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering services as well as a full range of health promotion and screening that reflected the needs for this age group. We saw that the practice provided a range of services patients could access at times that best suited them.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It carried out annual health checks for people with a learning disability and longer appointments were offered to them, and also for other patients' who required it.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Information was given to vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People 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. It also carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up and review patients' needs who had attended A&E who had been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 20 completed CQC comment cards from patients, of which, all were positive about their experience using the services provided. We spoke with eight patients on the day of our inspection. All patients we spoke with were complimentary about the care they received from the GPs and felt that staff treated them with dignity, compassion and respect.

We spoke with specific patient groups and they were able to tell us of their experiences, in particular patients with long term conditions and older people. We also spoke with patients from different age groups; including people who had retired. They were all very happy with the services the practice provided.

Patients told us the practice staff were always caring, attentive, polite and very knowledgeable. They said they felt they were always given enough time during their appointment and spoke highly of the GPs. As the practice provided care and support mainly for the older population, the staff could easily relate to patients as they were long-standing patients and were well known to all staff. We saw this in practice as part of our observations.

We saw that the practice was continually seeking feedback from patients to shape and develop services in the future. Patient views were listened to and the results of patient surveys reviewed quarterly. A 'compliments, suggestions and complaints' section on the practice website combined the review of the national GP survey results for 2014 and identified that 255 surveys had been completed by patients between January and September 2014. 90% commented that their GP was good at listening to them whilst 83% described their experience that their GP was good at involving them in decisions about their care. 98% of patients described they had confidence and trust the last time they saw a nurse.

Church Lane Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included an expert by experience, a GP and a practice manager.

Experts by Experience are part of the inspection team and are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Church Lane Medical Centre

The practice delivers primary care under a General Medical Services (GMS) Contract between themselves and NHS England for patients living in Scunthorpe, Ashby and surrounding areas. The practice has four GP partners, three male and one female. The practice was not currently a GP teaching practice however; the practice supported nursing students on an informal basis.

The practice opening times are from 08.00am – 18.30pm with pre-bookable appointments from 07.30am – 08.00am Tuesday to Friday. There are no Saturday appointments held at Church Lane Medical Centre. The practice does not provide an out-of-hours service to their own patients directly and patients are automatically diverted to the local out-of-hours service Safe Care when the surgery is closed in the evenings and at the weekends.

Why we carried out this inspection

We inspected this service as part of our inspection programme. This provider had not been inspected before This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may had poor access to primary care
- People experiencing a mental health problems

Detailed findings

Before visiting Church Lane Medical Centre, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We asked North Lincolnshire CCG and the Local Health Watch to tell us what they knew about the practice and the service provided. We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection visit on 4th February 2015. During our inspection we spoke with a range of staff including GPs, a practice nurse, nurse practitioners, a practice manager and administration and reception staff. We spoke with eight patients who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed 20 CQC comment cards where patients and members of the public shared their views and experiences about the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor patient safety and had a good track record for maintaining patient safety. We looked at the significant events analysis over the last year and saw that there were nine separate events identified. Learning and actions were recorded and dates of when reviews took place.

Staff were clear on what action to take in the event of an incident occurring. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, indicated that in 2013/14 the practice was appropriately identifying and reporting incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. We saw that any significant event had been recorded and there were documented details of the event, how learning was implemented and actions taken to reduce the risk of them happening again.

National patient safety alerts were communicated via computer alerts to practice staff. We saw that alerts were discussed at monthly practice meetings, to ensure that staff were aware of any relevant to the practice and where action needed to be taken. We saw examples where specific medicines had been discontinued and staff had been notified internally to ensure the latest medicines information was available.

Reliable safety systems and processes including safeguarding

There were policies and procedures in place to support staff to report safeguarding concerns to the named responsible GP within the practice and to the local safeguarding team. Staff we spoke with demonstrated an understanding of safeguarding patients from abuse and the actions to take should they suspect anyone was at risk of harm. Staff were clear how they would access procedures and policies should they need to raise any concerns.

We saw evidence that all staff had received different levels of safeguarding training for adults and children. The practice also identified a nominated professional as a safeguarding lead. The nominated lead had completed level three training to allow them to carry out the role as safeguarding lead. We saw records of monthly clinical meetings that included discussions around new and existing safeguarding concerns. Monthly meeting were also attended by health visitors and clinicians to ensure any changes were appropriately communicated for example palliative care.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. The practice had a named nurse to manage additional visits to patients which focussed on following up and safeguarding people following hospital visits.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All reception staff, including practice nurses, had been trained to be a chaperone.

Named GP contacts had been established for older people aged 75 and over and an unplanned admission register was in place. Follow up contact was made by nursing staff with patients who had not made contact with the practice and were deemed as more vulnerable.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies. System templates were in place to ensure that patient information was captured and recorded in a consistent and accurate manner.

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

Good

Are services safe?

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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 up to date medicines management policies and prescribing protocols in place. We saw that medicines for use in the practice were stored securely and only clinical staff had access to them. GPs did not have emergency drugs available to them for use on visits. We spoke with the practice manager about this and they provided us with an appropriate risk assessment analysis that included for example the proximity of the local pharmacy, the locality of the A+E department and speed of access to hospital services.

There were processes in place to ensure that stocks of medicines such as vaccines were readily available, in date and ready to use. We looked at how vaccines were ordered and saw that they were checked on receipt and stored appropriately in accordance with the manufactures recommendations.

Some medicines were stored in a lockable fridge and staff recorded the temperature daily to ensure medicines were stored in line with manufacturer's recommendations. Nurses carried cool bags on visits to ensure the 'cold chain' remained consistent with manufacturer's guidelines.

Staff were able to demonstrate the process and audit trail for the authorisation and review of repeat prescriptions. Prescription pads and repeat prescriptions were stored securely.

Cleanliness and infection control

We observed all areas of the practice to be clean and tidy. The practice had an infection prevention and control policy (IPC). The practice had a nominated infection control lead who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. They were responsible for completing monthly and quarterly internal audits and records we looked at corroborated this. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Vinyl curtains were used in clinical treatment rooms, which were labelled with cleaning dates. There were arrangements in place for the collection of general and clinical waste. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

There were processes in place to regularly check and calibrate equipment used in clinical areas. We saw records showing that equipment had been serviced and maintained at required intervals and to the manufactures recommendations. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

Staff we spoke with told us there was enough equipment in place to meet the needs of the practice. We saw that equipment checks were regularly carried out and staff were aware of who to report maintenance issues or faults to.

We saw that annual checks on portable appliance electrical (PAT testing) equipment had taken place and servicing arrangements were in place; for example for oxygen and pulse oximeter equipment.

Staffing and recruitment

The practice had a recruitment policy and process in place. We looked at five staff files and appropriate checks were carried out before the staff member began working within the practice. We saw that staff had their pre-employment references checked before employment started.

Staff had a recent Disclosure and Barring Service check (DBS) in line with the recruitment policy. We saw that there was an appropriate level of skill mix of staff in the practice.

Good

Are services safe?

Staff were able to share different tasks and workloads when the practice entered busy periods for patients. Staff told us that the levels of staff and skill mix were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy or responding to busy periods. For example, reception support was increased at busy times and other staff completed administration tasks.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available to staff on the practice computer system.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were allocated lead roles or areas of responsibility, for example safeguarding and infection control.

Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. The practice had systems in place to monitor patients within the population groups. For example those patients with long term conditions were reviewed with district nursing staff and hospital contacts. If required, palliative care representatives were engaged in detailed discussions regarding on-going care assessments.

The practice monitored patients health who were over the age of 75 and all patients had a named GP. All enquiries from this patient group were directed to their GP of choice whenever possible to ensure continuity of care and support.

Patients with long term conditions who had changes identified in their condition or new diagnoses were discussed at practice monthly clinical meetings. That allowed clinicians to monitor treatment and adjust according to risk. Therefore the practice was positively managing risk for patients. For example patients who required palliative care were discussed in multi-disciplinary team meetings and the practice was anticipating training in the very near future in the gold standards framework for palliative care.

The practice had appropriate equipment in place to deal with medical emergencies for all patient groups.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. All of the staff we spoke with knew how to react in urgent or emergency situations.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, incapacity of staff and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electricity company to contact if the electrical system failed. Staff we spoke with were aware of the practice business continuity arrangements and how to access the information they needed in the event of emergency situations.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed and updated when appropriate.

Staff told us they received guidance issued by the National Institute for Health and Care Excellence (NICE) electronically. They told us that the practice manager was responsible for circulating them to clinical staff. We saw examples where treatment guidance had been circulated to staff and acted on. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice.

National data showed that 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 of patients to secondary care and patients with suspected cancers who needed to be referred and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

The practice had a system in place for completing clinical audit cycles which was include in an annual audit plan. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two and four years. The audits were completed and the practice was able to demonstrate the changes resulting since the initial audit. One of the audits we looked at was regarding the number of patients over the age of 50 had undertaken Atrial fibrillation Screening (AF). AF is a heart condition that causes an irregular and often abnormally fast heart rate. Performance rates we looked at showed that the number of blood pressure sessions had increased and the practice had concluded there was a small increase in patients diagnosed with AF.

The practice used the information collected from the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months was 94.4% and 95.7% respectively, which was the average for CCG area.

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 on 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 clinical staff should undertake or be involved in the audit process.

There was a protocol for repeat prescribing which was in line with national guidance. The practice was an early adopter of electronic prescribing which provided patients with another option for ordering their prescriptions. This was in response to patient feedback and allowed patients faster access to prescribed medication via their nominated pharmacy. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being followed. The IT system flagged up relevant medicines

Good

Are services effective?

(for example, treatment is effective)

alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw that palliative care patients were also discussed at the daily meeting when there were changes to their condition.

The practice 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 that were 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 fire and basic life support. However, we saw some gaps in mandatory training for example display screen equipment and manual handling at work. We spoke with the practice manager and they gave us their assurance that all mandatory training would be brought up to date.

All GPs were up to date with their yearly continuing professional development requirements and either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which goals and objectives were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example Dementia and blood glucose monitoring. The practice was not currently a GP teaching practice however; the practice supported nursing students on an informal basis.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and review of patients with long term conditions.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x- ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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 that were not followed up appropriately.

The practice held regular palliative care meetings to discuss the needs of complex patients, for example those with end of life care needs, to which relevant professional were invited, and six weekly meetings with the previous Community Matron regarding patients on their case load. Decisions about care planning was documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, 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 their own outpatient appointments). Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the clinical and the patients care teams instant access to medical records at all of their surgeries. This enabled staff in the practice to see and treat patients

Good

Are services effective?

(for example, treatment is effective)

from other practices when registering as new patients. These records provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a processes in place to help staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Staff were able to identify patients who may need to be supported to make decisions and identify where a decision may need to be made in a person's 'best interest'. The practice offered an advocacy service where patients were identified as needing support during their care decisions. Information was available to all patients about this.

Patients with a learning disability 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). When interviewed, staff gave examples of how a patient's best interests was taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice asked new patients to complete a new patient registration form which included further information for carers and consent and data sharing guidance. The practice may then invite patients in for an assessment with one of the clinical staff. The registration form was detailed and asked the patients how they would prefer to communicate with the practice. This provided the practice an opportunity to promote different methods of communication such as electronic communication. The GPs were informed of all health concerns detected and these were followed up in a timely way.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 100%, which was above the national average. Performance for national child health, cardiovascular disease and cancer screening in the area was all above average for the CCG and a mechanism of following up patients who did not attend was used for these screening programmes.

The practice had a higher than average prevalence for most chronic diseases compared with the national average. The nursing team were responsible for monitoring registers for patients with long term conditions and a weekly Nurse led clinic was available for patients for example those with asthma or diabetes.

The practice offered a full range of immunisations for children. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders in the practice, these were also discussed with the Health Visitors.

There were comprehensive screening and vaccination programmes which were managed effectively to support

Good

Are services effective?

(for example, treatment is effective)

children and young people. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

We found evidence of good access and sign posting for young people towards sexual health clinics or offering extra services and contraception. The practice group had worked with local schools to ensure they provided access to services that were user friendly to young people and provided good information and access.

People experiencing poor mental health in the practice had access to services. We saw that people with severe mental health problems received an annual physical health check. We saw staff had undertaken additional training in mental health and addiction. There was a good understanding and evidence of signposting patients to relevant support groups and third sector organisations operating in the local area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The PPG was currently being re-introduced and no local survey information was available. However, evidence from the national patient survey the evidence from this source showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed the proportion of respondents to the GP patient survey who described the overall experience of their GP treating them with care and concern was 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We also spoke with eight patients on the day of our inspection The majority of comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful, caring and knowledgeable. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm professional manner. Staff we spoke with were aware of the importance of providing patients with privacy. They told us they could access a separate treatment room off the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate and any learning identified would be shared with staff and clinical staff as required.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were in line with national averages.

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.

The practice had engaged with the CCG and had actively participated in dementia screening for patients that were deemed at high risk. Patients that were identified as needing further tests were referred to the appropriate memory services for further reviews.

The practice had two designated 'carers champions' who actively sought patients who were carers. They offered advice and support to carers and liaised with local carers support charity. The carers support charity visited the practice on a monthly basis and offered advice to patients whilst they waited for their appointments.

Staff told us that translation services were available for patients who did not have English as a first language. We did not see any information in the reception area informing

Good

Are services caring?

patients this service was available. However, staff were able to describe the appropriate process to follow and include interpreter services where required and an appropriate translation service was also on the practice website.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 87% of practice respondents said the last appointment they got was convenient and 88% felt the GP was good at giving them enough time. Both these results were above average compared to CCG area.

Patients we spoke with 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.

GPs referred people to counselling services where necessary, and the practice website and handbook contained links to support organisation and other healthcare services. Patients could also search under their local area for further advice and support.

The practice provided information and support to patients who were bereaved and for carers. The practice sign posted patients to health and social care workers and referrals were made on behalf of patient's relatives and carers as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and 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.

The practice was in the process of re-introducing its PPG and therefore was developing its membership and patient feedback system over the next few months. We spoke to the standing PPG member and they told us there was a plan to consult with the original PPG lay member to develop and establish new support meetings and new membership in the near future.

Tackling inequity and promoting equality

Staff were knowledgeable about how to book interpreter services for patients where English was their second language. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The practice had recognised the needs of different groups in the planning of its services. Staff could access other support services, for example Age UK or the Alzheimer's Society for up to date information in order to support patients as needed.

Patients with disabilities and patients with pushchairs were able to access all areas of the building. The practice also had accessible toilet facilities that were available for all patients attending the practice. Two portable audio loops were available for patients who were hard of hearing. Level access with no step is provided for entry into the building and we saw that the consulting rooms were accessible for patients with limited mobility and there was also a toilet for disabled patients. Other facilities were available for mothers and babies; for example baby changing facilities.

Access to the service

Appointments were available from 08.00am – 18.30 Monday to Friday with in addition pre-bookable appointments available from 07.30am – 08.00am Tuesday to Friday. Saturday appointments were not currently available. The practice did not provide an out-of-hours service to their own patients directly and patients were automatically diverted to the local out-of-hours service Prime Care, when the surgery was closed in the evenings and at the weekends. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website.

All patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice offered text message reminders for appointments and test results. The premises were accessible for people with limited mobility such as wheelchair users and all patient areas were clean and well-maintained.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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 which was the practice manager.

We saw that information was available to help patients understand the complaints system in the waiting area, in the practice leaflet or the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 16 complaints received in the last 12 months and found these had been satisfactorily handled, dealt with

Good

Are services responsive to people's needs?

(for example, to feedback?)

in a timely way and learning outcomes had been recorded and implemented. We saw that the practice had an openness and transparency when dealing with the compliant.

We spoke with the one member of the PPG and they felt that the practice always took complaints seriously, handled them in a timely manner and resolved them fully.

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. We found details of the vision and practice values were part of the practice's future plans.

Examples of the practice vision and values included providing high quality, safe, professional services to patients, in an environment that is respectful to others. They told us that this was achieved by working in partnership with patients, their families and carers towards a positive experience and understanding.

We spoke with six 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 evidence of good communication with staff. The practice also had an extensive staff consultation process in place to ensure staff were consulted and their opinion valued.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and saw that processes were in place to ensure staff had read the policy and when. All of the policies and procedures we looked at had been reviewed and were current.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice held regular practice meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes of staff meetings that they were held regularly, at least monthly. 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 and with their line manager. We also noted that there was regular staff consultation.

The practice manager had responsibility for HR management across the practice. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We saw that these were easy to understand. We were shown the staff handbook that was available to all staff, which included sections on areas such as disciplinary and harassment at work.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We saw that following comments received by patients the practice had undertaken significant changes to how patients made telephone appointments and a new telephone system was implemented in July 2014.

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.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us the practice was supportive of training and we saw evidence to confirm this.

The practice was not currently a GP teaching practice however; the practice supported nursing students on an informal basis.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings

Are services well-led?

Good

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

to ensure the practice learned from and improved outcomes for patients. For example confirming what the most urgent issue at the start of a patient consultation when more than one issue is being discussed.