The Village 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?	Requires improvement
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

This is the report of findings from our inspection of The Village Medical Centre. Our comprehensive inspection was a planned inspection, which took place on 2 October 2014. The practice provides services in keeping with its registration with the Care Quality Commission (CQC), as responsible for providing primary care, which includes: diagnostic and screening, maternity and midwifery services and treatment of disease, disorder or injury.

Patients told us that they were very satisfied with the services they received and spoke very highly about the health care clinicians treating them.

Visiting healthcare staff from local NHS community services, who were attending the practice on the day of the inspection, told us about how they highly regarded the standards of collaborative and integrated care provided by this practice and how the practice focussed on the provision of patient centred services across all the population groups.

The Village Medical Centre is a training practice for fourth year medical students.

We have rated this service overall as good.

There was good access to appointments, patients were supported by a listening and responsive service

Our key findings were as follows: The service was patient centred seeking to provide safe and improving services in clean facilities, using effective systems and evidenced best practice and respecting people's privacy and dignity

We saw several areas of outstanding practice including:

The practice provided examples illustrating how the practice took time to send a practice nurse out to patients at home to monitor and support them and communicated their actions well to relatives of older people who lived far away from their family. Also, the practice made daily use of map of medicine healthguides. These care maps are made up of a series of

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steps. These include tests, treatments, referral to specialists, and links to other care maps. Their use supports best practice and they encourage joint decision making between doctor and patient.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:-

Ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice as required by the regulations of the Health and Social Care Act 2008. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant Disclosure and Barring Checks (DBS) are carried out, if necessary to the role, and the relevant information retained as required by the legislation.

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?

Requires improvement

We have rated this service as requires improvement. Clinical staff ensured that they were up to date with the most recent national and professional advice for treatment and care. Emergency equipment and medicines were available and correctly maintained.

All staff had received regular updated training in how to respond to medical emergencies.

Staff took action to safeguard adult and child patients and when appropriate made safeguarding referrals using clearly defined protocols. A range of effective hygiene and infection control measures were in place.

However, the provider did not have adequate arrangements to ensure the recruitment arrangements were in line with legislation to ensure necessary employment checks were in place for all staff. Key documentation was missing from staff files to demonstrate their fitness to work at the practice.

Are services effective?

Good

We have rated this service as good for effective.

All clinicians were trained and up to date. Opportunities had been provided for staff to keep up to date and receive update training as necessary. Suitable records of this training were kept which included certificated updates for clinician's skills. The GPs were very structured in their user of regular audits and evaluations to help them to maintain and improve clinical outcomes for patients. The practice had a clear and documented commitment to using cycles of continuous improvement.

All staff had regular, though generally informal, supervision and a documented annual assessment of their performance. This was recorded in order to identify strengths and where any developmental or training needs were identified these were included in a training plan for the upcoming year.

Are services caring?

Good

We have rated this service as good for caring. We spoke with seven patients from across different generations during the inspection and received nine completed Care Quality Commission (CQC) comment cards. Comments were very positive and spoke about the high quality of care received and the courtesy shown by all staff. Patients

Summary of findings

said they were treated with dignity and respect and had confidence in their healthcare professionals. Patients said they were confident that their confidential and personal information was kept private at all times.

Are services responsive to people's needs?

Good

We have rated this service as good for responsive. The practice ensured that everyone working at the practice maintained responsiveness to patient's needs. The practice ensured that it was aware of the identified areas of patients concerns and patient interests. Patients spoke very positively about the practice and said that they held the clinical and administrative staff in high regard.

The practice had not set up a patient participation group (PPG). However, the practice did make use of data and information. It did make efforts to consult the patients in order to plan and develop the practice and its services.

The practice had a complaints policy and the few complaints received were responded to in a timely manner.

Are services well-led?

Good

We have rated services as good for well-led. The practice was clinically and managerially well led. It effectively responded to changes in the provision of healthcare and the needs of the patient community. The lead GP had provided strong and clear leadership. A clear strategic strategy for the practice was in place.

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 rated this as outstanding. The practice served an established local community of different ages, but with a large community of older people. The practice was very clear about its ability to meet the health and social needs of older people in this advantaged area of Liverpool. A number of older people did not have family living close by and from time to time the practice provided exemplary service to patients at the request of family members and this included supporting patients at home with home visits made by the practice nurse and GPs if that was in the best interest of the older person.

Outstanding ☆

People with long term conditions
We rated this as good. Doctors made sure that people with long term conditions were supported by following the most up to date best practice guidelines. Patients' conditions were monitored, nurse led health clinics were provided and nurses supported patients to manage their on-going conditions, also using up to date best practice and information. Good use was made of a process called map of medicines healthguides which contributed well to the needs of this group.

Good

Families, children and young people
We rated this as good. Families, children and young people were supported by clinicians who had a special interest or experience in family planning and women's health. Young children were seen on the same day an appointment was requested. A well-baby clinic was held every other week. The practice had worked with parents and children to ensure that the care and treatment of children was well supported in the community as much as possible and that referrals to hospital based services took place only when necessary.

Good

Working age people (including those recently retired and students)
Working age people were able to receive advice, or make an appointment, or attend an appointment at suitable times.

Good

People whose circumstances may make them vulnerable

Not sufficient evidence to rate

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

People experiencing poor mental health had access to appropriate community support, timely referrals and adjusted length of appointment time if appropriate.

The practice coordinated with Inclusion Matters Liverpool – a service providing a range of talking therapies for common mental health problems such as anxiety and depression.

Summary of findings

What people who use the service say

Information from the 2012-2013 patient survey gave good feedback saying:-

Confidence and trust in GPs – 99%

Confidence and trust in Nurses- 88.18%

Helpfulness of reception staff – 86-02%

Patients we met with on the day of inspection were very positive about the practice. We met with seven patients from different generations. Everyone we spoke with had confidence in their clinicians.

We received nine completed Care Quality Commission (CQC) comment cards. These were very complimentary. Comments included: how pleased patients were with the clinical staff, some named their doctor with praise for the care they had received, there were positive comments about the helpful reception staff and a number spoke of their overall satisfaction with the practice. Many had been with the practice for a number of years. The younger patients we spoke with said that they felt treated with respect and were reassured by the kindness of the doctors. Parents said they were reassured by their children's comments about the practice.

Areas for improvement

Action the service MUST take to improve

The information contained in the staff records was not adequate and did not comply with the legal requirements. The provider must ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice as required by the Health and Social Care Act 2008 regulations. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant Disclosure and Barring Checks (DBS) are carried out, if necessary to the role, and the relevant information retained as required by the Schedule.

Outstanding practice

The practice provided examples illustrating how it had taken steps to monitor referrals and to ensure timely and appropriate referrals were made. These reduced unnecessary referrals to hospital and illustrated how the practice had been very proactive. The audit information recorded an effective and documented reduction in referrals in a short time frame. We heard about the needs and demands of the population groups in the community and saw how the practice sought to respond. In particular the commitment to being clinically up to date through daily access to map of medicine healthguides. Daily reference to these healthguides was exemplary. The steps taken by the map of medicine supported best practice and encouraged joint decision making between doctor and patient. The commitment to send a practice nurse member of the team to monitor and support patients at home when necessary was particularly noteworthy and effective in terms of patient outcomes.

The Village Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to The Village Medical Centre

The Village Medical Centre is located in the heart of Woolton. Woolton is described as a prestigious suburb in the south of Liverpool. This area has a life expectancy above the national average. The practice has a little over 3,500 patients and is located in a building which was successfully converted into a medical centre some 20 years ago. The facility is single storey brick and tile building which has been well maintained to a good standard. A spacious reception and waiting area is served by a patient toilet and baby changing area. There are two consulting rooms and two treatment rooms. Medical services are provided by a General Medical Services (GMS) contract by the three GPs. There are two partners and this will soon become a partnership of all three GPs providing a total of 90 hours GP time. There is one male GP and two female GPs. Supporting them is a team made up of two practice nurses (one whole time equivalent), a practice manager (whole time) and a team of seven reception / administrative staff (5.09 whole time equivalents).

Out of hours services are provided by "Urgent Care 24". Urgent Care 24 is an NHS out of hours primary care service for the population of Halton, Knowsley and Liverpool in Merseyside.

Why we carried out this inspection

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

This practice had not been inspected before and that was why we included them in this programme of routine inspection.

How we carried out this inspection

Before our inspection we requested data from Liverpool Clinical Commission group (CCG), information from NHS England and reviewed our own intelligent monitoring data. We were able to consider the services that would be required to meet the needs of all population groups, with age groups over 45 years of age being the numerically significant group of the practice.

Before our inspection, we sent comment cards and posters to the surgery advising patients of our inspection and inviting them to share their views. The practice did not have a patient participant group. We conducted a full day site visit on 2 October 2014. We spoke with all staff including reception and administrative staff, the new practice nurse and all three doctors. We also spoke with patients and their carers / parents.

Detailed findings

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice evidenced that they had a range of safety audits in place ranging from analysis of clinical practice, through services offered by the practice and health and safety of staff and the public who used the premises. Significant event analysis (SEA) had been carried out and documented. The outcomes of such analysis evidenced lessons learned and changes were implemented accordingly. For example, map of medicines on a daily basis. This demonstrated that the practice was consistently safe over time.

Staff explained to us how they could raise concerns through their management and reporting channels. They told us that through their meetings they could report any incidents in relation to matters of safety. Notes of these meetings were kept. Processes were in place which enabled reporting to external agencies if appropriate. At the time of our inspection a health and safety representative, commissioned by the Clinical Commissioning Group (CCG) was also carrying out a routine visit. This commissioned service carried out fire safety, health and safety, security, in house safety training and fire safety audits. Comprehensive records were seen and checked in relation to the maintenance and safety of the premises.

All of these processes worked well together to form a 'whole system' maintaining, recording and improving a comprehensive system of safety management.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events reviews were undertaken monthly. Significant alerts were examined every other morning and clinicians held discussions with their peers in order to review these. If outcomes or events were not as anticipated, patients were involved in this feedback as were any other relevant staff and a record kept. This multi-disciplinary approach enabled thorough investigations to be carried out as necessary. In turn this provided a consistent and transparent approach to processes which therefore enabled the team to pursue continual improvement.

Clinicians met daily to review events and any overnight developments.

Reliable safety systems and processes including safeguarding

Everyone we spoke with who was working at the practice had a good understanding of safeguarding issues. All members of the team at The Village Medical Centre knew about the systems, processes and practices which were essential to keep patients safe. All staff had received safeguarding training to a level which was suitable for their role. There were arrangements in place for level three training for at least one of the doctors. This training was arranged for 15 November 2014. Further refresher training for the other doctors was being arranged. Level three training was for clinical staff working with children, young people and/or their parents/carers. A level three safeguarding practitioner could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there were safeguarding/child protection concerns.

.A chaperoning policy was in place and arrangements clearly made known to patients.

Medicines Management

There were process in place for prescribing and reviewing prescription medicines. The practice made use of map of medicines healthguides on a daily basis. This was a process which maps pathways, information and decision making and gives clinicians information on the latest clinical evidence including evidence about medicines. It also enables improved clinical decisions based on best practice and facilitates joint decision making with doctor an patient.

Repeat prescriptions could be obtained by patients as necessary. Usually with one weeks' notice, but on the same day if medically necessary. Medicine audits were up to date and clear. Useful patient information about medicines was supported by information leaflets. Some emergency medications were available in the practice and were stored and managed correctly. Vaccinations were also kept correctly and within manufacturer's guidelines for the storage of vaccines.

Cleanliness & Infection Control

The practice had identified and named personnel who had lead responsibilities for cleanliness and the management and audit of infection control measures.

We spoke with staff who told us they were trained in infection control processes.

Requires improvement

Are services safe?

There were sufficient hand washing facilities and alcohol gel available throughout the premises.

There were sufficient quantities of gloves and aprons available. The consulting couches had paper rolls protecting them.

We saw evidence of audits for cleaning, infection prevention and control. The premises were visually clean and tidy throughout. There had been no reported incidents from sharps injuries or spillage.

We saw clinical and other waste was managed appropriately.

Equipment

Records were kept and these confirmed that all equipment in use was correctly maintained and safe for use.

Equipment required for resuscitation or other medical emergencies was available and was readily accessible for rapid use. Oxygen, an emergency bag and defibrillator were available. Personnel had been trained and staff had sufficient support and knew what to do in urgent and emergency situations.

Staffing & Recruitment

We looked at the arrangements for recruitment and for obtaining appropriate information

about staff working at the practice. We talked to staff about how they had been recruited. Some staff had worked at the practice for some years. They told us that they had applied for their posts through word of mouth or local job advertisements and that the practice had spoken to previous employers in order to find out if their conduct had been satisfactory. They had then undergone an interview at the practice.

We talked to the practice manager about recruitment process and checked five staff files. There is a legal requirement which sets out for providers all the information which should be obtained and recorded for staff working in the service. This required information was not present in the staff files. For example, when we looked at the staff files we did not see photographs, proofs of identity and health checks.

The practice manager told us that reception / administrative staff working in the practice did not have Disclosure and Barring Service (DBS) checks at all. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However, there was no practice policy in place at the time of inspection or individual assessments in relation to DBS and non – clinical staff.

We also noted that DBS checks were not in place for the nursing staff employed by the practice.

With regard to doctors; the practice believed that DBS checks were in place as conducted by the clinical commissioning group (CCG).

Locum doctors were used from time to time to provide cover for planned absences of the practice doctors. A service level agreement was in place and the practice was able to be reassured that the supplying agency carried out background checks on locum staff.

Administrative staff provided cover in-house from within the team.

Monitoring Safety & Responding to Risk

A full range of service, clinical and environmental risk assessments were carried out and documented.

For example, clinical risk assessments for patients with hypertension. Even though the practice was above target for managing / identifying risk to patients health the practice had sought to be even more risk aware of this health concern and through screening and opportunistic checks worked to reduce the risk even further.

Another example was in relation to patient referrals. Patients' requests for further consultations, treatment or opinions were received and evaluated by the other doctors in the practice. The resulting upturn in referrals was carefully analysed or monitored daily by the doctors reviewing each others referrals in order that the best clinical outcomes were consistently achieved.

Arrangements to deal with emergencies and major incidents

An up to date contingency plan was available, this included staff contact numbers and an agreed communication's strategy for contacting staff in the event of such emergencies. Staff were aware that having a plan in place meant that the practice was able to cope with a range of emergency or untoward events including power cuts and adverse weather conditions.

All staff were trained to a minimum of basic life support to ensure patients had emergency care if needed.

Requires improvement

Are services safe?

Fire alarm testing was completed monthly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed by healthcare professionals using relevant and up to date guidance. We saw that the practice made use of the map of medicine process on a daily basis rather than a weekly or monthly basis. Healthcare professionals use these maps as they show 'best practice' – the most effective way to treat a health problem – based on up-to-date evidence of what works. Each care map is made up of a series of steps. These include tests, treatments, referral to specialists, and links to other care maps.

Where patients needed their regular medication updated we noted that this was done after discussion by the doctor. Patients' medications were reviewed six monthly by the doctors. Once a year the doctor reviewed the medications in person with the patient. There were also examples of the practice nurse supporting patients at their home from time to time.

We also saw that the practice did not discriminate in its care treatment or services on any grounds.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included analysis of chronic obstructive pulmonary disease (COPD) and an audit looking at admissions to hospital due to a diagnosis of pneumonia. The practice had also carried out a detailed audit on fragility fractures and the use of medicines known as "Bisphosphonates". These are a class of drugs that prevent the loss of bone mass and are used to treat osteoporosis and similar diseases.

The practice routinely collected information about patient's care and treatment outcomes. It used the quality and outcomes framework (QoF) to assess its performance and undertook regular clinical audits as described above. QoF data and other national data returns showed the practice performed well in comparison to other local practices.

Annual appraisal documents showed that all clinical staff were engaged in audit processes. 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 at least one audit per year.

Patients' care and treatment outcomes were monitored and the outcomes were benchmarked against the clinical commissioning group (CCG) and national comparators. We saw reports demonstrating patient's health outcomes as part of regular practice and this gave the team confidence that patient's needs were being met. We saw that clinical audits were undertaken. For example, one clinician had audited Chronic Obstructive Pulmonary Disease (COPD), cellulitis and angina and had reflected on the outcomes and implemented appropriate action plans.

Effective staffing

Staff told us about their qualifications, skills and how they were relevant and necessary to their role. Clinicians evidenced that they were up to date and, where necessary, had revalidated their registrations and so were fully eligible to practice. Where roles had developed or extended, appropriate training had been provided. Learning needs were identified through a system of annual appraisal. Comprehensive audit and review systems in place also produced the benefit of staff being continually supported and supervised. Much one to one supervision was informal, but appraisal was formal. Peer support was in evidence at the practice and clinical supervision was delivered through the management structure. Clinical staff demonstrated that they reflected personally and with other professionals on their delivery of effective care and treatment in order to secure a cycle of continuous improvement.

The practice made use of a protected learning session once a month as facilitated by the CCG.

The practice had access to human resource professionals who could be called on as necessary. Processes were in place to support staff performance should that be required.

Working with colleagues and other services

There were clear arrangements and protocols in place for following up on patients that had been referred to other services or discharged from hospital. Systems were in place to ensure that clinicians communicated with patients to keep them informed. Also, there were good in-house systems for the receipt, recording and communication of results, notifications and referrals.

There was opportunity for patients to use a choose a book system and its use and uptake was monitored.

Good

Are services effective?

(for example, treatment is effective)

Clinicians were well acquainted with joint and multidisciplinary working across healthcare teams. Clinicians made appropriate and timely referrals and these were properly peer reviewed within the practice.

The practice gave a good account of how they were seeking to develop as an integrated team with other practices to deliver 'joined up services' for patients. We heard that every other month clinicians such as heart failure nurses, occupational therapists and physiotherapists met and linked together. These were steps being taken to develop integrated services.

We also met with visiting community nurses in the course of the inspection day. They spoke very positively about the various ways in which the practice consistently maintained high standards of collaborative working with them and so how together they could provide good services to patients.

Daily communication to and from the out of hours provider was good, timely and records were kept. Practice staff made a daily routine check on system called "workflow manager" each morning and following that check brought all relevant alerts to the attention of the GPs.

Information Sharing

Information helping clinician's to deliver effective care was correctly managed, securely kept and clearly communicated to the relevant clinician or other healthcare provider if that related to referral or transfers.

There was good management of safe, but effective patient information between paper and electronic systems and between relevant clinicians.

The practice ensured that regular palliative care meetings were held on a monthly basis. These meetings looked at the need of patient's receiving end of life care, including those with a diagnosis of cancer. These meetings also looked at the forward planning and preparation of palliative services.

Computer logs were kept for individuals in a range of identified groups. This helped the practice and its staff identify patients with certain needs in order to help to meet those needs. For example, vulnerable adults, patients with carers, patients with mental health needs and looked after children.

Same day appointments were offered to individuals in identified groups including young children.

The practice had a named GP for all patients aged 75 or over. Existing patients had been notified who their named GP was and newly registered patients were told within 21 days.

Consent to care and treatment

Clinicians told us about their understanding of how they sought patient's consent and how this was obtained in reference to legislation and professional guidance. They also gave good accounts about when adults or children needed support to make decision or if patients were not able to give consent. They were able to describe the key requirements of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. One of the doctors was scheduled to have training on 15 November 2014 which was to include training in relation to the Mental Capacity Act.

Health Promotion & Prevention

The practice sought to offer patients information and support to enable them to lead healthier lives. For example, new patients were offered a consultation. NHS health checks for 40–74 year olds were available. Anyone with a body mass index (BMI) over 30 were offered an advise session with a clinician.

Screening and vaccination programmes, including cervical screening and adult and child vaccinations, were offered and patients who were not able to attend were followed up.

The practice offered useful support to patients by 'signposting' or directing them to other relevant services for particular health and social care needs and support. This included self help and support groups.

A wide range of educational and informational leaflets were available in the practice.

Advice was provided directly from the doctors and there was dedicated support from the practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We received nine Care Quality Commission (CQC) comments cards from patients who used services at the practice and spoke with seven patients in person. They told us that they were very happy with the services they received at the practice and that they were treated with courtesy, dignity and respect. One patient told us that reception staff could sometimes be a little dismissive or hurried. However, other patients said that reception staff were kind and thoughtful. At the time of our visit we saw that reception staff were considerate, polite and gave patients and those close to them clear information, time and support.

Staff told us they could speak with their line manager directly if they had any concerns about any discriminatory or poor attitudes in the team and believed that any necessary action would be taken.

Reception staff were mindful of patient confidentiality and if necessary patients were able to speak in private or at least away from the open waiting area.

Care planning and involvement in decisions about care and treatment

Patients told us that clinicians clearly communicated with them in terms they could understand in relation to their diagnosis, treatment and treatment options. Clinicians took time to ensure that patients understood the options available to them. Patients told us they were clear about their treatment choices and felt able to ask questions or seek further information with the support of the all the practice staff, including clinicians and reception staff.

Where English was not a patient's first language arrangements were made for translators or use of a translation service. Staff knew how to make arrangements where advocates or people signing for the deaf were needed.

Various registers were kept. These computer registers included logs of patient's carers, older people, patients suffering from mental health conditions or learning disabilities, chronic conditions, dementia or cancer. These were kept and used to provide effective communication and support.

Patient/carer support to cope emotionally with care and treatment

Staff explained to us how they recognised the support patients and carers might need to cope emotionally with their care and treatment. Staff were able to support, direct or refer to other health and social care professionals, peer support networks and self-help groups as necessary.

Where bereavement support was needed patients were directed for further support by the practice to appropriate or specialist services such as the Liverpool Bereavement Service or the Alder Centre. The practice ensured that it made the out of hours service aware of patients who may have out of hour's needs, such as patients receiving end of life care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The Practice did not have a patient participation group (PPG) at the time of inspection, but was giving consideration to establishing a group. The practice had made use the quality outcomes framework (QoF) data. The practice demonstrated that it had given consideration of its performance, how that performance compared with others, and how it was succeeding in meeting local needs. The practice used this information to plan its services and to deliver them in ways which respected individuals, coordinated care with other agencies and providers and promoted health and well-being. The practice attended clinical commissioning group led events including neighbourhood meetings and education events.

The practice had implemented customer service training in response to one finding of the national patient survey (2012-2013) and this had raised the score for helpfulness of reception staff from 86.02% to 88.19%.

The services provided reflected the needs of the population served and included management of on-going conditions, health clinics, cervical screening, antenatal care vaccinations and immunisations.

The practice has two female and one male doctor and patients were able to make an appointment with a named doctor if they wished. Home visits were also made when necessary.

The premises offered disabled access via a ramp; disabled toilet, disabled parking, baby changing and children's play area.

Tackling inequity and promoting equality

The practice was committed to ensuring equal opportunities for access to services and treatments to all patients and avoiding discrimination on the grounds of age, gender, disability, status, orientation, race or religion. The practice sought to make appointments available to meet the needs of patients. We saw examples of the practice nurse going out to older patients if they needed help or supervision with aspects of their care and treatment and were unable to attend the practice, for example in relation to diabetic management. We saw that children were seen after school and that there were long appointment opportunities for patients with learning disabilities. Carers were given age and care related advice and support. Telephone appointments were available. We saw doctors going out on home visits and heard how patients and families with dementia were supported.

Access to the service

Patients told us that they were able to telephone the surgery. The national survey reported "89% easy to get through to this surgery on the phone". Patients also told us that they could make their appointment at a suitable and convenient time to them. Patients did not share any concerns with us about the availability of appointments. The surgery was open between 8am and 6.30pm with a practice nurse being available from 7am every Monday.

On the day of the inspection two elderly patients, who did not have an appointment, visited the surgery wanting to see the doctor that day. Staff had good personal knowledge of the patients and they created two additional appointments in order that these patients were seen by the doctor. Records indicated that this was not the first time this had happened and was indicative of a patient centred service.

Young children were seen on the same day that an appointment was requested.

The practice was developing its use of technology to support patients' access to healthcare. Telephone consultations with a clinician were available. We were told about an example where patients could receive a text message from the medical information computer system (known commonly as "EMIS") in use at the practice. Electronic prescribing of medicines was intended to be introduced by the end of 2014.

Doctors made home visits. We also noted that on occasions the practice nurse would visit patients in their own homes.

A choose and book system was available to patients. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Effectiveness and uptake of this system was monitored and evaluated by the practice who sought to ensure that it was of most benefit to the patient and responsive to their needs.

Services usually ran on time, but if there were disruptions reception staff were able to keep patients informed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

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

Patients knew about the complaint procedure and were able to make suggestions. This was also referenced on the Village Medical Centre web site. We asked to look at complaints received in the previous year. There were two and these had been investigated and actioned appropriately. Records were retained and any lessons learned had been incorporated into systems as part of the cycle of on-going improvement.

Any verbal comments, complaints or suggestions made were immediately actioned by the practice manager and any changes or improvements consequently made were communicated within the practice.

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 senior partner has set out high standards of service in this small practice over a period of years. The practice partners shared common values and through the close collaborative working of the three GPs a valued, patient centred vision has been established, understood and implemented through the whole team. This philosophy had been embedded in the culture of care and had promoted good outcomes for patients. There were regular reviews, audits analysis of significant events, staff appraisals, team and clinical meetings. These all worked together to deliver a visible leadership. These also demonstrated that the practice focussed on the importance of quality care delivered to patients with effective treatment outcomes for them.

The practice was considering how it could develop the premises to provide additional clinical areas to deliver additional services such as the taking of blood samples.

The practice had also considered its strategies for the three screening areas of bowel, breast and cervical screening and had exceeded in its performance in these areas if compared with the achievements of similar practices.

Immunisation rates for children were good and strategies for managing long term conditions were in place.

Governance Arrangements

There were systems in place addressing 'governance ' in the practice. These systems included such things as management arrangements, meetings, the production and analysis of data, personnel development and team performance. They ranged across the different aspects of the practice; clinical and non clinical. This included a programme of clinical audit. Clinical audit offers clinicians the best way of assessing the quality of the care which they had given and which they should strive to give.

These systems also included assessments of quality, practice efficiency, compliance with the most up to date guidelines and cost effectiveness. The practice looked at ways of engaging quality improvements. Included in those systems relating to staff and team culture, teamwork, staff training, measuring patient outcomes. This ensured that patients were kept at the heart of all that the practice was doing.

The data we saw indicated that referrals to hospitals were higher for older people than might be expected. The practice had introduced a programme of audit of referrals and this had resulted in a reduction in the referral rate whilst maintaining good service to this population group.

Leadership, openness and transparency

Staff told us they felt there was clear and effective leadership in place. They said that they were supported. Staff said that there was an open door culture and they would be confident that any concerns or questions would be listened to. Staff said they were treated fairly and compassionately Some staff had experienced bereavements in the last year and had been well supported by the team during that time.

Meetings were documented and the records indicated an open and communicative culture.

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

Staff gave a good account of how they contributed to the development of practice policies and the wider operational strategy. This included opening times for the surgery. They told us that there were regular meetings and we saw the minutes of those meetings.

A whistleblowing policy was in place and staff were aware of it.

A suggestion box was available in the waiting room and the web site invited suggestions from patients and the public.

The practice participated in a regular neighbourhood meeting.

The practice had looked at the NHS national patient survey and the team were aware of it. The survey made very positive comments about the practice and was available online.

Management lead through learning & improvement

The management team made sure that all clinical and administrative staff were aware of the benefits of continual learning and how that learning could be included in maintaining best practice and in making improvements. The practice nurse gave examples of how the practice supported her in maintaining clinical professional development through training and mentoring. Annual appraisals included any new objectives.

Are services well-led?

Good

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

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not have adequate recruitment arrangements in place in accordance with Schedule 3 of the Health and Social Care Act 2008. The required employment checks were not in place for all staff. Key documentation was missing from staff files to demonstrate their fitness to work at the practice**