Edenbridge Medical PracticeEdenbridge Medical Practice

Quality Report

Westview
Station Road
Edenbridge
Kent
TN8 5ND
Tel: 01732 865055
Website: www.edenbridgemedicalpractice.nhs.uk

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

Summary of findings

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Overall summary

Edenbridge Medical Practice is a GP practice providing care for 12,100 patients.

There are four partners in the practice and a further six salaried GPs. The GPs are supported by a practice manager, a nursing team of three registered nurses and two health care assistants, and administrative staff consisting of receptionists, clerks and secretaries. Edenbridge Medical Practice is a dispensing practice and this is staffed by trained dispensing staff.

As part of the inspection we talked with the local clinical commissioning croup, the local healthwatch, two representatives of the patient participation group, patients who were at the practice on the day of the inspection, GPs, other clinical and non-clinical staff at the practice.

We had some concerns about the safety of medicine management at the practice. This was in relation to how emergency medicines and some medicines carried in the GPs bags were managed and the potential risks related to expired medicines.

All of the patients we spoke with were very positive about the care and treatment they received and they were complimentary about the staff at the practice. We received positive comments from patients who had completed comment cards prior to our inspection visit. All of which stated that they were happy with the support, care and treatment provided by all staff. Patients told us they experienced difficulties in booking appointments. This was also highlighted in the patient survey in 2013. The practice management team had recognised this as an issue and had researched how this element of the practice could be improved.

Overall, we found that the practice was well-led and provided caring, effective, and responsive services to a wide range of patient population groups, however, we had some concerns about medicines management which affected all population groups.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We had some concerns about the safety of medicine management at the practice. This was in relation to how some medicines carried in the GPs bags were managed and the potential risks related to expired medicines. In addition some of the emergency medicines were missing from one emergency box.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. We found that systems were in place to ensure staff learned from significant events/incidents. There were child and adult safeguarding policies and procedures in place. The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice. We found that the practice had effective recruitment procedures in place to ensure that staff employed were of good character, had the skills, experience and qualifications required for the work to be performed. The practice had both an emergency and business continuity plan in place. Service and maintenance contracts were in place with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Are services effective?

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. The practice used QOF audits results for managing, monitoring and improving outcomes for patients. There were processes in place for managing all staffs' performance and professional development. We found the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies.

There was a robust induction programme available. Recently recruited non-clinical staff told us they had completed this training, but records were not maintained to support that the programme had been completed.

Are services caring?

Patients experienced a caring practice. We found that patients' needs were assessed and care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the service. Patients' privacy and dignity was respected and

Summary of findings

protected and their confidential information was managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Are services responsive to people's needs?

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received. Patients told us they had difficulties getting through to the practice by telephone in order to make an appointment. The GP partners were aware of this issue and had taken appropriate action to address it. Information about how to complain was made readily available to patients and other people who used the practice (carers, visiting health professionals). Complaints were appropriately responded to and in accordance with the practice's complaints policy.

Are services well-led?

The practice was well-led. There were clear lines of accountability and responsibility within the practice. We found that the management team provided open, inclusive and visible leadership to the staff. There were appropriate systems in place to share best practice guidance, information and changes to policies and procedures to the staff. Governance arrangements were in place, to continuously improve the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, in order to ensure improvements were made. Risks to the practice and service provision had been appropriately identified and action taken to reduce or remove the risk had been undertaken.

Summary of findings

The six population groups and what we found

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

Older people
We found the practice to be caring in the support it offered to older patients. We saw that there were appropriate and effective treatments, along with ongoing support for patients in this population group. The practice had systems in place to enable it to be responsive to meet the needs of older patients and to recognise future demands in service provision for this age group.

People with long-term conditions
The practice was caring in the support it offered to patients with long-term conditions and the care provided was effective. Treatment plans were monitored and kept under review by a multi-disciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Mothers, babies, children and young people
We found that the service was caring and effective in relation to mothers, babies, children and young patients. The practice offered dedicated clinics to patients in this population group. We saw that referrals to other community based services were made, in order to provide these patients with additional support. The practice had a named GP who specialised in family planning. Systems were in place to ensure that patients who required family planning support, care and treatment, received this effectively and responsively. The practice was responsive in prioritising appointments for mothers with babies and young children. The practice was well-led in relation to nominating a named GP to have overall responsibility for children and adult safeguarding matters and systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers.

The working-age population and those recently retired
The practice had systems in place to be effective and responsive in meeting the needs of patients in this population group and were providing extended hours to make the practice more accessible to working age patients. The patient participation group were looking at ways of recruiting new members from this patient population group and ways to see how they could improve how they engaged with them.

Summary of findings

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

We found that the practice was caring, effective and responsive in relation to vulnerable patients, who may have poor access to primary care. We saw that there were support systems in place for vulnerable patients and the practice was responsive to providing care and treatment at patients' homes, where they had difficulty in attending the practice. We saw that the practice had procedures in place for vulnerable patients to support them to consent to treatment. There was a wide range of services and clinics available to support and meet the needs of this population group. We saw that the premises were accessible and suitable for patients with reduced mobility and provided enough space for wheelchair users. The practice was responsive to addressing issues raised in patient surveys, relating to changes required at the practice for patients with reduced mobility or wheelchair users.

People experiencing poor mental health

We found the practice had a caring and responsive approach to patients who experienced mental health problems. There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems and their carers relevant referral to other specialist service providers for ongoing support. Effective systems were in place to monitor and assess patients who lacked mental capacity to make informed decisions for themselves. We found that patients' carers were supported to make decisions for patients they held responsibility for. Carers' views and opinions were considered when care and treatment was required. Appropriate referral systems were in place, when support was required by the GPs in order to assess patients' mental capacity. The practice management team provided a well-led approach in relation to identifying and managing risks to patients who experience mental health problems.

Summary of findings

What people who use the service say

We spoke with six patients at the surgery, received comment cards from five patients and we looked at feedback the practice had received through complaints, compliments and the patient survey coordinated by the patient participation group (PPG).

All of the patients we spoke with were very positive about the care and treatment they received and they were particularly complimentary about the staff at the practice. We were told by patients that staff were caring, supportive and sensitive to their needs.

We received positive comments from patients who had completed comment cards prior to our inspection. Most of which stated they were happy with the support, care and treatment provided by all staff. Two stated that the reception staff were very helpful and friendly.

We spoke with two representatives from the PPG, who told us about the effective systems in place to encourage a supportive, engaging and effective working relationship with the practices management team.

The patient survey for 2013 highlighted that the current telephone system meant that patients and carers experienced problems in booking appointments, the entry doors to the practice were difficult for patients with mobility problems to manage.

Patients told us they felt listened to during consultations. They also told us they had no concerns or complaints about the practice but knew how to raise concerns and complaints if they needed to.

Areas for improvement

Action the service MUST take to improve

The practice must undertake a review of the management of medicines at the practice, including those medicines kept and used for emergencies and medicines stored in GPs' bags for home visits to ensure they are within date.

Edenbridge Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP. The team included a practice manager.

Background to Edenbridge Medical Practice

Edenbridge Medical Practice is a GP practice based in the town of Edenbridge. The practice offers primary medical services. These services are provided by a team of ten GPs, a practice manager, three practice nurses and two healthcare assistants. They are supported by receptionists, clerks and secretaries.

Edenbridge Medical Practice serves patients living in Edenbridge and surrounding areas. There were 12,100 patients on the list at the time of our inspection.

The practice serves a population with low levels of deprivation. Edenbridge Medical Practice is wheelchair accessible. Opening times for Edenbridge Medical Practice are Monday to Friday 8am to 6pm, with extended hours on Monday, Tuesday and Thursday from 6.30pm to 8.30pm.

Services are provided to a wide range of patient population groups.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local clinical commissioning group and local Healthwatch to share what they knew about the practice. We carried out an announced visit on 22 May 2014. During

Detailed findings

our visit we spoke with a range of staff including three GPs, two practice nurses and reception staff as well as the practice manager. We spoke with six patients. We observed how patients were being cared for and talked with carers and/or family members. We saw how telephone calls from patients were dealt with. We toured the premises and looked policies and procedures. We reviewed five comment cards where patients and members of the public shared their views and experiences of the practice. We also spoke with two representatives from the patient participation group. We observed how patients were supported by the reception staff in the waiting area before they were seen by the clinical staff (GPs, nurses and health care assistants).

Are services safe?

Summary of findings

We had some concerns about the safety of medicine management at the practice. This was in relation to how some medicines carried in the GPs bags were managed and the potential risks related to expired medicines. In addition some of the emergency medicines were missing from one emergency box.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. We found that systems were in place to ensure staff learned from significant events/incidents. There were child and adult safeguarding policies and procedures in place. The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice. We found that the practice had effective recruitment procedures in place to ensure that staff employed were of good character, had the skills, experience and qualifications required for the work to be performed. The practice had both an emergency and business continuity plan in place. Service and maintenance contracts were in place with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Our findings

Safe patient care

We saw that systems were in place to process urgent referrals to other care/treatment services and to ensure test results were reviewed in a timely manner once they had been received by the practice. There was a system in place to check test results and clinical information on a daily basis.

We found there were regular meetings held by different staff groups. We were told by a GP and the practice manager that there was a palliative care meeting held every three months, which was attended by the GPs, a palliative care nurse and one of the practice nurses. The practice manager told us all staff met quarterly to discuss the practice and any issues. In addition, the GPs met weekly and minutes of these meetings were kept. Information received from other health and social care professionals during these meetings was used to provide a unified approach to their care.

We saw that safety alerts from outside agencies were received by either the principal GP or the practice manager. Safety alerts provide information to keep the practice up to date with failures in equipment, processes, procedures and substances used in the general practice. Any information received in relation to safety alerts was then cascaded either electronically or during practice meetings, to the GPs. We looked at audits related to safety alerts and saw that these provided a clear audit trail of actions taken by the GPs to ensure patients safety. National data collected from incidents/events and alerts was monitored, assessed and used to improve patient safety within the practice.

Learning from incidents

We found that systems were in place to ensure staff learned from significant events. There was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors. We saw that these issues were reported to the practice manager who created a report that was subsequently discussed by the partners. We were told by GPs that adverse events were discussed at weekly practice meetings, in order to review all of the significant events in a formal manner. We looked at the minutes from these meetings and they included evidence of discussions, actions taken to address issues and lessons learnt from any incident/event.

Are services safe?

Safeguarding

One of the GPs was designated to be the lead in overseeing safeguarding matters. There was a protocol and contact numbers for child and adult protection referrals available to all staff. Clinical staff we spoke with told us they were aware of the protocol and the procedures to follow if they had to report any concerns.

Other health care professionals, who had contact with vulnerable children and adults, were involved in safeguarding the patients from the risk of harm and abuse as multidisciplinary safeguarding meetings were held at the practice and attended by the health visitor for the area. These meetings were used to discuss patients who may be on the 'at risk register'. Individual cases were discussed and plans put in place to meet patients' needs and keep them safe.

We found that there were child and adult safeguarding policies and procedures in place. All staff were knowledgeable and had received training in both safeguarding adults and children. From staff recruitment files we found all staff had been subject to a criminal records check through the Disclosure and Barring Service (DBS).

Monitoring safety and responding to risk

The practice had systems and procedures in place for responding to medical emergencies. Staff we spoke with, and training records confirmed, that all clinical staff had received training in emergency life support. Staff told us they were aware of the emergency procedures to follow.

We saw that weekly GP meetings were held and minutes of these meetings detailed how decisions were made about house calls and duty doctor arrangements, to ensure there were sufficient hours provided for patient appointments, including emergency appointments.

We spoke with both clinical and non-clinical staff who were knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs. There was a duty doctor system in place to ensure that the practice could provide greater flexibility amongst the GPs to respond to cover absent GPs (for example those who worked part time), busy periods and any emerging risks to patients throughout the day.

We spoke to GPs and non-clinical administrative staff about the computer based safety alert system in place. We were told that this enabled staff to summon assistance if needed. To show that the practice was able to respond quickly when an emergency situation occurred, we were given an example of how the system was used recently and how the response from staff was appropriate.

Medicines management

The practice has an on-site dispensary. We looked at the arrangements for the dispensing of medicines to patients. We spoke with the pharmacist and dispensing staff, who had received appropriate training in pharmacy services. Medicines were prepared, and the prescriptions checked and counter-signed by doctors on a daily basis before being collected/issued to patients. We observed that the dispensary room was clean and orderly. Sharps containers were appropriately assembled and all had audit labels completed to identify their origin and the date they were assembled or sealed.

There were clear stock records and audit checks kept of the medicines held in the dispensary. Staff told us that an annual stock check was undertaken and expiry dates were checked. There was a barcode system in use for all medicines held at the dispensary and the computer system in use allowed for stock levels to be checked at any time. We found that where medicines did not have a barcode, there were effective systems in place to monitor and record these medicines appropriately. There was a system for two staff to check all medicines (with or without a bar code), to ensure they were dispensed safely.

Security procedures for the dispensary were formally recorded, for example, to identify how and when the room was locked and who had access to it. We saw that the dispensary had appropriate arrangements for the secure storage and administration of controlled drugs, including the control of keys, a separate drugs register and two signatures were recorded when a controlled drug was dispensed.

We saw from records that adverse incidents relating to medicines were appropriately recorded and that actions had been taken to address these, for example, a patient was dispensed an incorrect dose of medicine and this was discovered during checks and immediately resolved. As a result of this incident monitoring and checking systems were updated. The pharmacist told us that since the introduction of the bar code system, errors of this nature had not occurred.

Are services safe?

We spoke with GPs, the pharmacist and members of the non-clinical team, who told us there was a system for checking that repeat prescriptions were issued according to medicine review dates and to ensure, that patients on long-term medicines were reviewed on a regular basis. Patients told us they had not experienced any difficulty in getting their repeat prescriptions.

We looked at the refrigerator for the storage of medicines that required storage at a certain temperature. We found that the temperature of the refrigerator was monitored and documented. We saw that the refrigerator was kept locked when not in use to ensure that refrigerated medicines were kept safely and securely.

We found that there was a robust process in place to help monitor the security of prescription pads for use in the printers so that the practice could track when they were used.

We looked at the way in which medicines used for medical emergencies were maintained. We found that medicines were within their usable date. There were two boxes of emergency medicines held within the practice and in one box we found three medicines, which were listed as being within the box, were missing. There were no records in place to show how or when these had been checked so the practice was not able to identify when they had gone missing, or whether they had been used.

We checked the medicines held in GPs bags for home visits. We saw that one GP had a controlled drug in their bag and this was monitored appropriately by the GP and the pharmacist. We saw that a controlled drug register was used to provide an audit trail of when the drug was dispensed, when and who it had been administered to, expiry dates, how it had been discarded and replaced. We looked at the medicines held by another GP in their bag and found that three medicines had expired between 2012 and 2013. There was no monitoring system in place for medicines besides controlled drugs, in GPs bags, and patients were at risk of receiving out of date medicines.

We looked at the way in which equipment used for medical emergencies was monitored and maintained. Single use equipment remained wrapped in its original packaging and was in date. The practice had oxygen and an automated external defibrillator (AED) for use in an emergency. Records were kept in relation to the routine checking of equipment for use in a medical emergency.

Cleanliness and infection control

We looked at the premises and found all the areas of the practice were clean and tidy. We saw that liquid hand wash and disposable towels had been provided in the public toilets. We saw a notice about the importance of effective hand washing displayed in public areas. This meant that patients had information about the importance of hand washing to reduce the spread of infection.

Clinical rooms had clinical waste bins, along with liquid soap and disposable paper towels. We found that the privacy curtains used in clinical rooms were disposable and that there was a schedule in place for routinely changing them.

We saw that sharps bins had been dated and information about safe disposable of clinical waste and sharps was displayed. In the consulting rooms we saw that disposable couch rolls were in place and could be changed for each patient. There was personal protective equipment (PPE) available in the clinical rooms. We saw from records that the practice had a contract in place for the safe disposal of clinical waste. This helped ensure the risk of infection was minimised.

The practice had an infection control policy in place; however the policy did not state the name of the designated infection control lead, although there was one in place. We found audits of deep cleaning were carried out, however; there was no guidance in place for staff, to inform them how often deep cleaning should be carried out. We found that there were no cleaning schedules to verify that all areas of the practice had been appropriately cleaned and who was responsible for cleaning specific areas of the practice, for example the practice or cleaning staff. The lack of monitoring checks, guidance or cleaning schedules meant the practice could not ensure good standards of cleanliness were carried out or maintained.

Staff told us they had received training in infection control, and we saw evidence of training updates in infection control for all members of the clinical staff team. All staff were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control.

Staffing and recruitment

The practice had a recruitment policy that reflected the recruitment and selection processes completed by the practice. We looked at nine staff files and saw that appropriate checks had been carried out. All staff had a

Are services safe?

completed criminal records check through the Disclosure and Barring Service (DBS). The practice manager told us that checks with the General Medical Council (GMC) and to the Nursing & Midwifery Council (NMC) were routinely in place to ensure staff maintained their professional registration.

We spoke with the GPs and practice manager about staffing levels within the practice. They told us there were strategies in place for the clinical team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. We were told that recent shortages caused by staff sickness in the nurse team had required the use of an agency nurse and in order for continuity for patients, the practice had tried where possible to always have the same agency nurse.

There were sufficient staff at the practice, patients did not have any difficulties accessing a GP or nurse appointment and received appointment times appropriately. Patients told us they never had to wait for long periods of time, unless they had requested to see a specific GP or nurse.

Dealing with Emergencies

The practice had both an emergency and business continuity plan in place. We found that the plan included details of how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services, for example, extreme weather that caused staff shortages and any interruptions to the facilities available. We were told by the principal GP that discussions had been held between the partners to look at remote working (working from home) in cases of extreme weather. At the time of our visit the partners were researching this as a possibility, to ensure that patients could still have access to a consultation if the GP was unable to be physically present at the practice.

Equipment

We saw that processes and systems to keep the premises and building safe for patients, staff and visitors were in place. Records showed there were service and maintenance contracts with specialist contractors, who undertook regular safety checks and maintained specialist equipment. Equipment and the premises were appropriately checked to ensure they promoted staff, patient and visitors safety. We saw that training had been provided to staff in respect of fire safety awareness and a member of staff was appointed as a fire warden. The premises had an up-to-date fire risk assessment and regular fire safety checks were recorded. There was a planned maintenance plan in use by the practice which took into account accessing equipment in the event of equipment becoming faulty. Records of portable appliance testing (PAT) of electrical appliances were seen during our visit.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. The practice used QOF audits results for managing, monitoring and improving outcomes for patients. There were processes in place for managing all staffs' performance and professional development. We found the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies.

There was a robust induction programme available. Recently recruited non-clinical staff told us they had completed this training, but records were not maintained to support that the programme had been completed.

Our findings

Promoting best practice

The practice used national guidance and professional guidelines to promote best practice in the care it provided. We were told by GPs that patients received care according to national guidelines. We saw that relevant guidelines and national strategies were made available to staff.

We saw that that patients were offered care and treatment in accordance with nationally recognised standards. We were shown records of medicine audits that had been carried out following the receipt of national guidelines and standards provided to the practice by NHS commissioners and other stakeholders. For example, we saw that a change had been made to the prescribing regime for patients with a specific condition, following an update in best practice guidelines.

We spoke with clinical staff who told us that patients' needs and potential risks were assessed at initial consultations with the clinicians. We were told that individual clinical and treatment plans were agreed and recorded on the computerised system.

Management, monitoring and improving outcomes for people

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients with specific conditions/diagnosis, for example, patients with dementia, asthma, heart disease, diabetes.

We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. We saw that QOF audits were used to inform clinical meetings where information from audits were shared and discussed amongst relevant staff. Actions were agreed with regards to changes to specific treatments and therapies, if required, in order to improve outcomes for patients.

There were systems in place, to ensure patients received care and treatment that was appropriate to their condition. We were told by a GP that they performed their own clinical audits which they used as evidence for their appraisal. We were shown records of an audit which looked at osteoarthritis and joint injections. From the audit we saw an option grid had been implemented, the grid was designed to help patients and GPs decide how best to

Are services effective?

(for example, treatment is effective)

manage pain, activity levels and treatment options available. Plans were in place to re-audit the changes to measure improvements or whether any further changes were required.

Staffing

We saw from records, and from information shared by staff we spoke with that there were processes in place for managing staff performance and professional development. Staff knew who was responsible for managing and mentoring them. We were shown records that confirmed all staff had completed Basic Life Support (BLS), information governance, infection control, confidentiality and safeguarding children and adult training. Nurses had also completed specialist training in diabetes, asthma, family planning, travel vaccines, epilepsy, coronary heart disease, chronic obstructive pulmonary disease (a long-term respiratory disease) and updates in childhood immunisations. We were told by clinical staff that they attended external meetings and events to help further enhance their continuing professional development. Health care assistances were also provided with specialist training in asthma, phlebotomy (taking blood samples) and also supported to train to become practice nurses, if they wished to do so.

We saw from clinical staff records that they received regular training updates. We were told by all staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the support they required to enable them to perform their roles effectively.

We saw that an induction programme had been undertaken by non-clinical members of staff who had recently joined the practice. From this record we saw that induction programmes were not always recorded as having been completed although staff said that they had.

Working with other services

We saw from minutes of meetings that the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies. These processes ensured that links with the palliative care team, health visitor and district nurses for example, remained effective and promoted patients care, welfare and safety. Multi-disciplinary meetings were held routinely and included clinicians from the practice and all members of the multi-disciplinary team who were involved in patients' care and treatments.

Health, promotion and prevention

The non-clinical administrative staff told us about the processes for informing patients that needed to come back to the practice for further care or treatment. We saw for example, that the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us that they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

We saw a range of information leaflets and posters in the waiting room for patients to get information about the practice and about promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed.

We spoke with two of the nurses who conducted the various clinics. They explained how they would explain the benefits of particular lifestyles to patients with long-term conditions such as diabetes, asthma, epilepsy and coronary heart disease. This meant that patients had the knowledge to live as healthy a lifestyle as their conditions permitted.

Are services caring?

Summary of findings

Patients experienced a caring practice. We found that patients' needs were assessed and care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the service. Patients' privacy and dignity was respected and protected and their confidential information was managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with and those who completed comment cards told us that they felt the staff at the practice were polite and helpful. Comments from patients were positive in relation to staff and the care and treatment that they received.

Three patients told us that staff always considered their privacy and dignity. We checked to see how the practice maintained patients' privacy and dignity. The clinical staff we spoke with demonstrated how they ensured patients privacy and dignity both during consultations and treatments. Examples of this were ensuring that curtains were used in treatment areas to provide privacy and to ensure that doors to treatment/consultation rooms were closed.

We found that systems were in place to ensure that patients' privacy and dignity were protected at all times. We saw that the practice had a confidentiality policy in place, which detailed how staff should protect patients' confidentiality. Staff we spoke with, both clinical and non-clinical were aware of their responsibilities in maintaining patient confidentiality. The practice manager told us that if patients wished to speak to reception staff in confidence, that a private room would be made available for them to use. Although the reception area was open plan the reception telephones were placed in a way that meant conversations on the telephone could not be heard by patients waiting for an appointment. We spoke with patients and were told that they felt their consultations were always conducted appropriately.

We saw that the practice had a chaperone policy in place that set out the arrangements for patients who wished to have a member of staff present during intimate clinical examinations or treatment. We saw from staff training records that they had received up-to-date chaperone training. From our observations of the premise we saw notices informing patients that they could ask for a chaperone to be present during their consultation if they wished to have one.

Involvement in decisions and consent

We looked at how the practice involved patients in the care and treatment they received. We found that patients' involvement in care and treatment was appropriate. We

Are services caring?

were told by the patients we spoke with that they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen to them, and explained all treatment options available to them. They said they felt they were able to ask questions if they had any. We were told by staff that patients could see the doctor of their choice, although they acknowledged that patients sometimes had to wait a longer period of time if they wanted to see a specific GP. We saw a range of information leaflets and posters in the waiting room for patients to get information about the practice and about promoting good health. This meant that patients were involved in decision making and had the time and information to make informed decisions.

The practice had procedures in place for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer or parent/guardian had signed on the patients behalf. A nurse described how they managed issues with gaining consent from patients who were unable to write. The process in place was clear and we were told by the nurse that they documented clearly the reason why written consent had not been obtained and the reason for accepting verbal consent.

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. All GPs were knowledgeable about how and when to make referrals and had access to the British Medical Association guidance about the Mental Capacity Act 2005. We were assured that the procedures in place ensured patients who lacked capacity were appropriately assessed and referred where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the practice was responsive to patients' needs. The practice, along with the support of their patient participation group, enabled patients to voice their views and opinions in relation to the quality of the services they received. Patients told us they had difficulties getting through to the practice by telephone in order to make an appointment. The GP partners were aware of this issue and had taken appropriate action to address it. Information about how to complain was made readily available to patients and other people who used the practice (carers, visiting health professionals). Complaints were appropriately responded to and in accordance with the practice's complaints policy.

Our findings

Responding to and meeting people's needs

We were told by GPs and the practice nurses how patients' needs and potential risks were assessed during initial consultations. We were told that individual clinical and treatment plans were agreed and recorded on the computerised system. One GP and the practice manager told us that individual clinical and treatment plans were discussed with other healthcare professionals during meetings, held between clinical staff and other health care professionals involved in patients care and treatment. This was to ensure that patients received care and treatment from health care professionals that were aware of their individual clinical and care plans.

GPs described how they discussed with individual patients and carers, which consultant to refer them to based on the patients needs and individual preferences. GPs told us that they tended to refer patients locally, as this was what most patients preferred. However, referrals to one of the London hospitals were made if it was appropriate and requested by the patient or their carer.

We saw from records and from the information shared with us by staff, that the practice had well established links with the local area commissioners. We were told by a GP that meetings took place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future.

The practice had a patient participation group (PPG) and meetings had been conducted to discuss terms of reference and the purpose of the group. We saw that a questionnaire had been developed to distribute to patients and we saw an analysis of the results of previous questionnaires which were completed by patients. We were told by the PPG representatives that they had looked at ways of recruiting new members from all of the patient populations groups. Plans were also in place for members of the PPG to have a stall at a local community event, to further raise awareness of their existence. We saw that the practice had a website containing a section dedicated to the PPG, where recent surveys and the group's annual report could be accessed by patients and members of the public.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet

Are services responsive to people's needs?

(for example, to feedback?)

the needs of the varied patient groups. They told us they would refer patients to community specialists or clinics, if appropriate. Examples of this were referring older patients, or their carers, to groups who specialised in supporting patients and carers with chronic illnesses and mothers with babies or young children to the health visitor. We were told that the practice did not provide out of hours care and this was provided by another service provider, which patients could access via telephone.

The practice worked closely with the community nursing team, health visitor and the multi-disciplinary team to ensure the needs of patients were met. We were told by patients that when a referral was required, they were referred promptly.

Access to the service

From our observations we saw that the premises were accessible for patients with disabilities, with ramps to gain entry into the practice and appropriate parking spaces close to the entrance door. There was a toilet available for people with disabilities, which had recently been renovated, as the practice had recognised that the existing facility was too small for wheelchair users. We observed the reception desk was not at a low level to accommodate patients using wheelchairs. However, reception staff came to the front to speak to patients if necessary. The patient survey conducted by the PPG in 2013 showed that the entry doors to the practice were difficult for patients with mobility problems to manage. In response the practice were researching automatic doors and in the interim had placed a door bell at the entry, which rang in reception to alert staff that a patient needed assistance.

We found patients could book an appointment by telephone, online or in person. Patients we spoke with told us they found the telephone appointment booking system (for contacting the practice for an appointment on the same day) did not work very well. The main complaints raised by patients concerned the early morning telephone booking system. Patients told us they could either not get through during the early morning or if they did, they could not get an appointment because they had already been allocated. The patient survey conducted by the PPG in 2013 also showed that the top dissatisfaction was the inability to get appointments on the day, book appointments in advance and to see a GP of their choice. The practice had reviewed this result and researched the cause. It was recognised that the changes over the last few years due to GPs leaving and the number of GPs who were part time, meant that this had impacted on patients. The practice had conducted an audit of booking appointments, which resulted in changes to the appointment booking system. Staff numbers were increased at peak times to answer the telephone in the early morning and schedules for appointments were changed to provide more sessions for patients to try and address this concern. A further review to monitor the impact of the changes was planned.

Patients we spoke with told us they did not experience problems when they required urgent or medical emergency appointments. They told us that once they made contact with the practice, staff dealt with these issues promptly and knew how to prioritise appointments for them. The reception staff we spoke with had a clear understanding of the triage system. This was a system used to prioritise how urgently patients required treatment, or whether the GP would be able to support patients in other ways, such as a telephone consultation or home visit. Patients found that access to urgent or emergency appointments met their needs and expectations.

There was a system in place for patients to obtain repeat prescriptions. Patients told us that they had not experienced any difficulty in getting their repeat prescriptions. We were told by staff that they aimed to have repeat prescriptions ready within 48 hours of them being given in by the patient, so that they received their prescriptions in a timely manner.

Concerns and complaints

The practice had a complaints policy in place. We saw practice meeting minutes in which complaints were included. Patients we spoke with told us that they had never had cause to complain but knew there was information in the waiting room about how and who to complain to, should they need to.

We saw records relating to five complaints which were made to the practice. The complaints were investigated and the outcome of each investigation was sent to the respective complainant. We saw from letters sent to complainants that the contact details of the ombudsman was also included. This gave patients the option of taking their complaint further, if they were not happy with the way in which the practice responded. We saw that the practice

Are services responsive to people's needs?

(for example, to feedback?)

manager also kept a log of all informal complaints.
Particular issues that required change were shared at the practice meetings to ensure that all staff learnt from the complaints that had been made.

Are services well-led?

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

Summary of findings

The practice was well-led. There were clear lines of accountability and responsibility within the practice. We found that the management team provided open, inclusive and visible leadership to the staff. There were appropriate systems in place to share best practice guidance, information and changes to policies and procedures to the staff. Governance arrangements were in place, to continuously improve the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, in order to ensure improvements were made. Risks to the practice and service provision had been appropriately identified and action taken to reduce or remove the risk had been undertaken.

Our findings

Leadership and culture

We were told by all the staff that we spoke with that there was an open and inclusive culture at the practice. Both clinical and non-clinical staff said that their views and opinions were valued. They told us they were positively encouraged to participate in meetings and improve service provision. Staff meeting minutes confirmed that information and instructions were communicated by the GPs and practice manager to the staff.

Staff we spoke with told us that there was a clear management structure that included allocations of responsibilities. There were named staff to take on various roles, for example, there were leads for safeguarding, family planning and minor surgery. The practice had a stable staff team.

The staff we spoke with told us that they felt there was an open door culture within the practice, that they felt appropriately supported and were able to approach the senior staff about any concerns they had. We spoke with a representative from the patient participation group (PPG), who confirmed that staff at the practice were open to criticism and suggestions and valued feedback from patients and the PPG.

Governance arrangements

We looked at the governance arrangements in place at the practice and saw that these included the delegation of responsibilities to named GPs, for example, a lead for safeguarding. We saw that the lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required.

We were told by staff that significant events were openly discussed at team meetings and team meetings were used as a platform to learn from incidents and errors.

Systems to monitor and improve quality and improvement

We looked at the systems in place to monitor and improve the quality of service provision. We found that the practice achieved high scores in the Quality and Outcome Frameworks audits (QOF), which meant that the practice was performing well against other GP practices. The practice used information from QOF audits to further monitor the quality of the services provided to patients.

Are services well-led?

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

Patient experience and involvement

Patient engagement was managed through the PPG and through comments and complaints raised with the practice manager. The PPG representatives that we spoke with during our visit told us that the management team were open and responsive to suggestions. They also told us the practice supported regular patient surveys to consider ways to improve the services provided. We saw a detailed action plan which was generated by the management in response to the findings of the patient survey in 2013. This gave examples of where changes were required such as ways to improve the telephone system, patient population size and impact on the practice and improvements required to the car park and general décor of the premises. We saw that patients experience was reviewed and their involvement was used to support the changes made to improve service provision.

Staff engagement and involvement

We found that staff were encouraged to attend and participate in regular staff meetings. We were told by staff that meetings included discussions about changes to procedures, clinical practice, and staffing arrangements. All staff told us they felt part of the team. Staff told us that whilst there was strong leadership, the atmosphere at the practice was both open and inclusive. Staff told us that they were very happy working at the practice and felt listened to and valued. The practice had a whistleblowing policy and staff told us they were aware of the procedure to follow if they wished to raise concerns outside of the practice. Staff were encouraged to voice their ideas and opinions about how the services were provided and run.

Learning and improvement

We looked at how the practice learnt from significant events, incidents and training and how these improved services provided to patients. Staff told us that training updates provided them with information on current best practice or how improvements could be made at the practice. They told us training was discussed openly at team meetings and we found that team meetings were used to learn from training attended by staff and feedback from complaints and incidents.

We saw from minutes of meetings and from the information shared with us by staff, that patient referrals were discussed confidentially at clinical team meetings. We found that areas of learning were discussed, considered and shared between clinicians.

We were told by GPs that meetings were held between them and the practice manager to discuss and recognise future demands that may be placed on the practice. Examples of these were explained as being; using information and intelligence to plan for the needs of an increasing older patient population and those with long-term conditions, and the prevalence of certain conditions such as heart disease and dementia. We saw that the increased needs for service provision had been considered and planned for.

Identification and management of risk

We saw from records, and from information shared with us by staff that there were systems and processes in place to manage risks. We saw that risk assessments were used to consider individual risks to patients. Records showed that assessments had been completed in order to consider and determine possible risks to the practice, such as business continuity and disruption, loss of the premises and loss of facilities. We were told by a GP and the practice manager that the partners also discussed the business of the practice and concerns identified were used to inform risk assessments. We saw that an up to date fire risk assessment was in place and that all staff knew their roles and responsibilities in the event of a fire.

Older people

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

Summary of findings

We found the practice to be caring in the support it offered to older patients. We saw that there were appropriate and effective treatments, along with ongoing support for patients in this population group. The practice had systems in place to enable it to be responsive to meet the needs of older patients and to recognise future demands in service provision for this age group.

Our findings

Caring

We found the practice to be caring in the support it offered to older patients. There were appropriate and effective treatments, along with ongoing support; such as medical reviews, referrals when necessary and review clinics, for those patients diagnosed with dementia, diabetes and other illnesses.

The practice had formal links with two local care homes for older patients, who were patients registered with the practice. Systems were in place to provide regular and ongoing care and support to these patients. This enabled patients to have continuity of care and support with their ongoing and more complex health care needs.

Responsive

Every patient who was over 75 had been an allocated to a named GP. This population group had been contacted to inform them which GP they were allocated to and to inform them that they could see any GP, not just the one allocated to them.

The practice ran specialist clinics in order to provide older patients with annual flu vaccinations. The practice offered reviews and assessments to check that vital signs and lifestyle choices as well as weight, blood pressure and diet, were within the expected range for patients in this population group.

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients over 75, with specific conditions, for example patients with dementia, heart disease and diabetes. The practice maintained these registers in order to know the exact number of patients within this population group and how appointments, care and treatment could be tailored to meet their needs.

The practice acknowledged that the patients they supported included a significant number of older patients. The management had considered how future planning would respond to the needs of patients in this age group.

People with long term conditions

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

Summary of findings

The practice was caring in the support it offered to patients with long-term conditions and the care provided was effective. Treatment plans were monitored and kept under review by a multi-disciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Our findings

Caring

We saw that there were appropriate treatments, along with ongoing support; such as medical reviews, referrals when necessary and review clinics, for those patients diagnosed with chronic obstructive pulmonary disease, coronary heart disease, diabetes and other illnesses. We were told by GPs how individual clinical and treatment plans were agreed and recorded. We were told by a GP and the practice manager that individual clinical and treatment plans were discussed with other health care professionals, during meetings held between the practice clinical staff and other health care professionals. This was done to ensure that patients with long-term conditions received care and treatment, from health care professionals that were aware of their individual clinical and care plans.

Effective

There were processes to ensure that links with district and community nurses and other nurse specialists, remained effective and promoted patients care, welfare and safety. Multi-disciplinary meetings were held routinely and included clinicians from the practice and all members of the multi-disciplinary team who were involved in the provision of care for patients with long-term conditions care and treatments.

Nurses had completed specialist training in diabetes, asthma, epilepsy, coronary heart disease and chronic obstructive pulmonary disease (a long-term respiratory disease). Regular specialist clinics were run by nurses in order to assess and regularly review patients with these long-term conditions.

Responsive

The practice prioritised appointments for patients with long-term conditions. We were told that patients could be

People with long term conditions

seen at the practice, receive home visits or have telephone consultations and that patients could choose which option suited them according to how their long-term condition made them feel on the day.

Mothers, babies, children and young people

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

Summary of findings

We found that the practice was caring and effective in relation to mothers, babies, children and young patients. The practice offered dedicated clinics to patients in this population group. We saw that referrals to other community based services where made, in order to provide these patients with additional support. The practice had a named GP who specialised in family planning. Systems were in place to ensure that patients who required family planning support, care and treatment, received this effectively and responsively. The practice was responsive in prioritising appointments for mothers with babies and young children. The practice was well-led in relation to nominating a named GP to have overall responsibility for children and adult safeguarding matters and systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers.

Our findings

Safe

To ensure that information received from other service providers was used to improve patient safety, we were told by a GP that the computer system flagged up an 'alert' for babies and young children who had been placed on the 'at risk' register. We were told that the system also flagged up frequent visits to hospital Accident and Emergency departments that were followed up by the practice.

Caring

We were told by clinical staff that appointments and clinics were arranged to meet the care needs of patients in this population group, for example, family planning, maternity issues and childhood immunisation.

Effective

The practice had a GP who had the lead role for family planning. From records we saw that the GP had completed training in family planning and had undertaken an update in 2014, in order to ensure patients received care and treatment in line with current best practice and guidance.

We looked at clinics held for patients requiring insertion of intrauterine devices and hormone implants (a coil inserted into the womb or implant injected under the skin in order to prevent pregnancy). We saw that patients were seen by the GP who risk assessed them to ensure they were suitable for this treatment option. Patients were then seen by either their GP or the nurse and written information was provided to them about the treatment and what to expect during the procedure. Appropriate consent forms were in use for these procedures. The practice had a range of information and leaflets to provide to patients about how to care for themselves following the procedure, the leaflets included information on who to contact if they experienced any complications.

The practice routinely made referrals for mothers with babies and young children to the community health visitor

Mothers, babies, children and young people

in order to provide an additional level of support. The practice also offered regular baby and child immunisation clinics and post-natal clinics, for example, six week mother and baby checks.

The practice supported the patient participation group to engage with mothers who had babies and young children, as well as young patients.

Responsive

We saw that the lead GP for family planning maintained a list of patients who had an intrauterine device. The list was used to monitor how long patients had their device in place and to prompt appointments for check-ups and removal and replacement of the device.

We saw that the practice had baby changing facilities available.

Well led

The management at the practice had identified a named lead for safeguarding adults and children who had specific responsibility for giving information and training to other staff within the practice.

Working age people (and those recently retired)

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

Summary of findings

The practice had systems in place to be effective and responsive in meeting the needs of patients in this population group and provided extended hours to make the practice more accessible to working age patients. The patient participation group were looking at ways of recruiting new members from this patient population group and ways to see how they could improve how they engaged with them.

Our findings

Effective

The practice offered a range of services and clinics to provide monitoring and routine support for working age patients (and those recently retired), including lifestyle and healthy living checks, blood pressure and weight checks.

Responsive

The practice supported the patient participation group (PPG) to engage with patients of working age patients (and those recently retired). We saw that a questionnaire had been developed to distribute to patients and we saw an analysis of the results of previous questionnaires which were completed by patients. We were told by a PPG representative that they had looked at ways of recruiting new members from this patient population group. We were told that survey responses were lacking from this group of patients, and as a result there were plans for members of the PPG to have a stall at a local community event to further raise awareness of their existence and recruit new members.

The practice had extended opening hours and surgery times for working age patients, who could find it difficult to attend appointments during core working hours. Extended hours were available on Monday, Tuesday and Thursday from 6.30pm to 8.30pm. We were told by staff that these appointments were well attended by commuters.

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

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

Summary of findings

We found that the practice was caring, effective and responsive in relation to vulnerable patients, who may have poor access to primary care. We saw that there were support systems in place for vulnerable patients and the practice was responsive to providing care and treatment at patient's homes, where they had difficulty in attending the practice. We saw that the practice had procedures in place for vulnerable patients to support them to consent to treatment. There was a wide range of services and clinics available to support and meet the needs of this population group. We saw that the premises were accessible and suitable for patients with reduced mobility and provided enough space for wheelchair users. The practice was responsive to addressing issues raised in patient surveys, relating to changes required at the practice for patients with reduced mobility or wheelchair users.

Our findings

Caring

The practice had formal links with a local care home for patients with a learning disability, who were patients registered with the practice. Systems were in place to provide regular and ongoing care and support; such as medical reviews, referrals to other healthcare providers when necessary and review clinics, to these patients. This enabled patients to have continuity of care and support with their ongoing routine and health care needs.

Effective

We saw that there were effective support systems in place for vulnerable patients, for example, the practice offered care and treatment in patients homes, where they had difficulty in attending the practice. GPs and the practice manager told us that visits to care homes were conducted for patients who were unable to attend the practice. We were told that patients who reside at the care home for patients with a learning disability were supported to attend the practice for appointments, where possible.

We were told by GPs and the practice manager that the practice provides care and treatment to patients who live on a local static traveller's site. The practice provided home visits, where required and liaised closely with community health workers and support groups, in order to ensure the needs and expectations of these patients were met.

We saw that the practice had procedures in place for vulnerable patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer had signed on the patients behalf. A nurse described how they managed issues with gaining consent from patients who were unable to write. The process in place

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

was clear and we were told that all clinical staff at the practice were aware that they should document clearly the reason why written consent had not been obtained and the reason for accepting verbal consent.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of this population group. They told us that they would refer patients to community specialists or clinics, if appropriate.

Responsive

From our observations we saw that the premises were accessible for patients with disabilities, with ramps to gain entry into the practice and appropriate parking spaces close to the entrance door. There were specialist facilities available for patients with reduced mobility and/or wheel chair users. We saw that the toilet with facilities for the people with disabilities had recently been renovated as the practice had recognised that the existing facility was too small for wheelchair users. We observed the reception desk was not at a low level to accommodate patients using wheelchairs. However, staff came to the front of the desk to speak to patients. The patient survey conducted by the PPG in 2013 showed that the entry doors to the practice were difficult for patients with mobility problems to manage. In response the practice were researching automatic doors and in the interim had placed a door bell at the entry, which rang in reception to alert staff that a patient needed assistance.

We were told by a PPG representative that they had approached the local travelling community, with a view to recruiting new members to the group. On this occasion, the offer to join was declined.

Well led

The management team recognised and acknowledged that the practice had identifiable vulnerable patient groups within the locality of the practice. We saw that where patients were identified as particularly vulnerable, mechanisms had been put in place to help ensure equality of access to the practice and the services provided; such as booking appointments for home visits, telephone consultations and referring these patients to other specialist healthcare providers for example.

People experiencing poor mental health

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

Summary of findings

We found the practice had a caring and responsive approach to patients who experienced mental health problems. There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems and their carers, relevant referral to other specialist service providers for ongoing support. Effective systems were in place to monitor and assess patients who lacked mental capacity to make informed decisions for themselves. We found that patients' carers were supported to make decisions for patients they held responsibility for. Carers' views and opinions were considered when care and treatment was required. Appropriate referral systems were in place, when support was required by the GPs in order to assess patient's mental capacity. The practice management team provided a well-led approach in relation to identifying and managing risks to patients who experience mental health problems.

Our findings

Caring

We were told by GPs and the practice nurse about how the needs of patients with mental health problems, were assessed during initial consultation. We were told by a GP and the practice manager that individual clinical and treatment plans were discussed with other mental health care professionals during clinical meetings held between clinical staff and mental health workers. This was to ensure that patients received care and treatment from healthcare professionals that were aware of their individual clinical and care plans.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of this population group. They told us that they would refer patients to community specialists or clinics; such as counsellors and registered charities which support patients with mental health, if appropriate.

Effective

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity assessments were carried out by the doctors and recorded on individual patient records. We were told of instances that required further assessment of patients where they lacked capacity and how referrals were made. We saw that procedures in place ensured that patients who lacked capacity were appropriately assessed and referred, where applicable.

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients with mental health problems. We saw that these registers were used to inform clinical audits, which were undertaken within the practice such as; maintaining lists of patients prescribed medicines used to manage mental health conditions. From minutes of clinical meetings we saw that information from

People experiencing poor mental health

audits were shared and discussed and actions were agreed with regards to changes to specific treatments and therapies, if required, in order to improve outcomes for patients with mental health problems.

We saw a range of information leaflets and posters in the waiting room for patients to get information about the practice and about promoting good health. Information about how to access other mental health services and support groups such as MIND (a mental health charity), were also displayed. This helped patients access the services they needed.

As well as the GPs and nurses employed at the practice there were established links to refer patients experiencing mental problems to other health care providers, such as psychologists, counsellors and support workers. The practice consistently scored highly in the Quality and Outcomes Framework audit results relating to the care of patients experiencing poor mental health.

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
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 - Management of Medicines. **How the regulation was not being met:** Patients who use the practice were not protected against the risks associated with unsafe management of medicines because the provider did not have arrangements or processes in place to check and, monitor medicines used for emergencies and home visits. (Regulation 13)