Henley-in-Arden 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.

Summary of findings

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Summary of findings

Overall summary

Henley-in-Arden Medical Centre provides primary medical services to patients living in Henley-in-Arden, South Warwickshire and the surrounding area. A team of five doctors, two nurses, two health care assistants and 11 administrative staff including a practice manager provided care and treatment for approximately 6800 patients. Henley-in-Arden Medical Centre is a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine.

We spoke with 12 patients on the day of our inspection who were all very complimentary about the care and treatment they received. They told us all the staff were friendly, helpful, professional, kind and caring. We reviewed the 26 patient comments cards from our Care Quality Commission (CQC) comments box within the practice. Comments were overwhelmingly positive. We looked at the results of the annual patient survey completed in partnership between the Patient Participation Group (PPG) and the practice. The overall results demonstrated that patients felt very happy with the services they received.

We found that the service was safe because there were systems in place to protect patients from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. There was a genuinely just and open culture, which embraced concerns from staff and patients for their learning potential. However, we found that Patient Group Directives for the safe administration of vaccines were not always signed or easily accessible.

We found that the service was effective. Care and treatment was delivered in line with current published best practice achieving good outcomes for patients and promoting a good quality of life. The process of gaining informed consent however, may not have always supported vulnerable patients because not all staff were aware of the implications of the Mental Capacity Act 2005.

We found that the service was caring. All the patients we spoke with told us that staff treated them with compassion, kindness, dignity and respect. Feedback from patients and those close to them was consistently positive about the way staff interacted with patients.

The service was responsive because services were organised in conjunction with its community to enable patients to access services. There was an open culture within the organisation and patient suggestions for improving the service were acted upon.

We found that the service was well led. The leadership, management and governance of the practice assured the delivery of high-quality care, supported learning and innovation and promoted an open and fair culture.

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 found that the service was safe because there were systems in place to protect patients from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. There was a genuinely just and open culture, which embraced concerns from staff and patients for their learning potential.

Are services effective?
We found that the service was effective. Care and treatment was delivered in line with current published best practice. This achieved positive outcomes for patients and promoted a good quality of life. Patients' needs were consistently met in a timely manner. The provider was making effective use of the Royal College of General Practitioners' clinical audit tool to assess the performance of its doctors. There was a comprehensive schedule of internal audits.

Are services caring?
We found that the service was caring. All the patients we spoke with told us that staff involved and treated them with compassion, kindness, dignity and respect. Feedback from patients and those close to them was consistently positive about the way staff interacted with patients.

Are services responsive to people's needs?
We found that the service was responsive because services were organised in conjunction with its community to enable patients to access services. There was an open culture within the organisation and a clear complaints policy. Patient suggestions for improving the service were acted upon.

Are services well-led?
We found that the service was well led. The leadership, management and governance of the practice assured the delivery of high-quality care. It supported learning and innovation and promoted an open and fair culture.

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

Older patients were safe because the provider monitored the safety of older patients and responded to the risks identified. They received effective care, treatment and support that achieved good outcomes and was based on best practice. Older patients received compassionate care which was responsive to their needs. Services for older patients were well led because the provider worked closely with the CCG responding to feedback and making arrangements at practice level to improve care and treatment where needed

People with long-term conditions

Patients with long term conditions were safe because the provider provided annual checks following NICE guidance to ensure patients received appropriate care. Patients received an effective service that met their needs by working in partnership with other services. Patients received compassionate care which was responsive to their needs. Services for patients with long term conditions were well led. There was a clear vision to deliver high quality care and promote good health outcomes for patients

Mothers, babies, children and young people

Mothers and their children received a service that was safe because there were systems in place to protect children from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. They received an effective service that met their needs by working in partnership with other services. Patients received compassionate care which was responsive to their needs. Services for mothers and their children were well led. There was a clear vision to deliver high quality care and promote good health outcomes for patients

The working-age population and those recently retired

Working age patients were kept safe because there were screening services to enable the early detection and treatment of some cancers. They received an effective service because improvements to clinical care were made following a clinical audit. Patients received compassionate care which was responsive to their needs. Services for working age patients were well led because the provider worked closely with the CCG by responding to feedback they provided. They made local arrangements at practice level to improve care and treatment where needed

Summary of findings

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

Patients in vulnerable circumstances received a service that was safe because there were systems in place to protect vulnerable adults from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. They received an effective service that met their needs by working in partnership with other services however, not all staff were aware of the implications of the Mental Capacity Act 2005. This is important when gaining consent from patients who may lack capacity to make informed decisions. Patients received compassionate care which was responsive to their needs. Services for patients in vulnerable circumstances were well led. There was an established management structure which clearly identified the clinical lead for safeguarding vulnerable adults

People experiencing poor mental health

Patients experiencing poor mental health received a service that was safe and effective because the provider worked with other services to identify risks to patients. Patients received compassionate care which was responsive to their needs. Services for patients experiencing poor mental health were well led because risks identified were assessed and action plans to manage the risks were available within the practice's business continuity plan.

Summary of findings

What people who use the service say

The 12 patients we spoke with on the day of our inspection were very complimentary about the care and treatment they received. They told us all the staff were friendly, helpful, professional, kind and caring. We reviewed the 26 patient comments cards from our Care Quality Commission (CQC) comments box that we had placed in the practice prior to our inspection. We saw that comments were overwhelmingly positive. We looked at the results of the annual patient survey completed in partnership between the Patient Participation Group (PPG) and the practice. The overall results demonstrated that patients felt very happy with the services they received at the practice. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care.

Areas for improvement

Action the service COULD take to improve

- Ensure all staff are aware of the importance of the Mental Capacity Act 2005 when obtaining consent from patients.
- Ensure that Patient Group Directives for the administration of vaccines are signed and easily accessible.

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice actively pursued creative and innovative approaches to care and treatment such as:
- Staff away days seeking the views and ideas of the whole team in the development of new approaches to service provision.
- The development of monthly health news bulletins for patients. These were cascaded to the wider population through local organisations and newsletters such as Henley News on Line.
- Proactive outreach programmes and service adaptations aimed at increasing the uptake of the flu vaccination for elderly patients living in residential caravan parks and sheltered housing.
- Saturday morning 'commuter clinic sessions' for patients who worked full-time and could not access the practice mid-week.
- Weekly meetings between the GP safeguarding lead at the practice and the Health Visiting service discussing a partnership approach to provide additional support to parents and children in need.
- There were specific clinical leads within the practice and clearly defined lines of accountability.

Henley-in-Arden Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor, a second CQC inspector and an expert by experience.

Background to Henley-in-Arden Medical Centre

Henley-in-Arden Medical Centre provides primary medical services to patients living in Henley-in-Arden, Warwickshire and the surrounding area. The service moved in 1990 to the purpose-built premises in Prince Harry Road. A small car park provides parking for patients with one disabled parking space available for patients with mobility difficulties. A team of five doctors, two nurses, two health care assistants and 11 administrative staff including a practice manager provides care and treatment for approximately 6800 patients. A phlebotomy service is also provided by the practice. Henley-in-Arden Medical Centre is a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed findings

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced inspection on 15 May, 2014. The inspection team spent nine hours inspecting Henley-in-Arden Medical Centre. During our inspection we spoke with three GPs, one GP registrar, two nurses, one health care assistant, three receptionists, the practice manager, a visiting professional and 12 patients. We observed how patients were cared for and spoke with carers and family members. We reviewed the 26 patient comment cards sharing their views and experiences of the practice.

Are services safe?

Summary of findings

We found that the service was safe because there were systems in place to protect patients from abuse and avoidable harm.

Our findings

Safe Patient Care

Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks to patients. Staff were able to describe to us the systems they used to report and record incidents, complaints and significant events. They understood why this was important in keeping patients safe. The provider kept a log of incidents that occurred at the service, complaints and significant events. All of the incidents were investigated and there were systems in place, such as monthly team meetings, to share learning with staff. There was an annual review of complaints, incidents and significant events to identify if there were any reoccurring concerns across the service.

Learning from Incidents

There was learning from incidents. We looked at the provider's records for the investigation of near misses. We found that a GP had prescribed the correct medication for a patient but the local pharmacy had put the right medication into a wrongly labelled bottle. The GP contacted the local pharmacy and raised their concerns with them to ensure that the same type of incident was not repeated. The provider awaits feedback from the pharmacy regarding their analysis of this significant event. The provider held a weekly management meeting where complaints and incidents were discussed.

We looked at the provider's records of complaints. We found that the provider had experienced a complaint whereby a patient reported that their confidentiality had been breached whilst at the reception area. We saw practice meeting minutes that demonstrated that key learning points were identified and shared with staff. Action was taken to improve systems, operating procedures and staff practices. This included results and prescription requests being taken over the telephone away from the reception area. We saw that this was carried out on the day of our inspection and staff we spoke with were aware of these changes. Staff were also provided with confidentiality training by an external provider and we saw training certificates to support this. A recent patient survey demonstrated that patients were happy with the level of confidentiality now provided at the reception area.

Patients were safe because learning and action was taken following external incidents and near misses. There was a

Are services safe?

protocol in place for the management of handling external safety alerts. The protocol clearly identified the practice manager as responsible for sharing this alert and in their absence, a deputy. The practice manager described to us the processes they followed when the service received safety alerts from external sources such as the Medicines and Healthcare Regulatory Agency (MHRA). Staff confirmed the recommendations of these alerts were shared with them and demonstrated an understanding of why this information sharing was important.

Safeguarding

Patients were kept safe because the provider had taken reasonable steps to embed safeguarding systems within their practice to protect children and vulnerable adults from harm. We saw training certificates that showed staff had been provided with training in safeguarding children and vulnerable adults at a level appropriate to their role. Some GPs had received the higher level three safeguarding training and the remaining GPs were booked to attend in June 2014. Staff we spoke with understood how to safeguard patients from abuse and what they would do if they suspected anyone was at risk of harm. There were up to date policies in place for safeguarding vulnerable adults and children from abuse which clearly identified clinical leads and lines of accountability. The policies contained information to support staff in recognising and reporting safeguarding concerns to the appropriate agencies for investigation. Staff told us that they were aware of these policies and where to locate them. This meant staff were supported in their decision making about the safe protection of patients because they had guidelines to refer to.

The provider worked with other services to prevent abuse and to implement plans of care. We spoke with a visiting professional on the day of our inspection. They told us that they had weekly face to face meetings with the designated safeguarding lead for children to discuss how to manage and support children and families in vulnerable situations. They gave us examples of when they had worked with the GP to support children in vulnerable circumstances, mothers with postnatal depression or supported patients experiencing domestic abuse. The visiting professional told us, "They (the provider) are accessible, inclusive and I feel confident they will listen to me. There is an open and transparent culture and they ask me questions and value my input. It's good, it works".

Monitoring Safety & Responding to Risk

Staffing establishments were reviewed to keep patients safe and meet their needs. The provider informed us that patients had told them of their need for a phlebotomy service at the practice due to the distance elderly patients were required to travel to have their blood taken for diagnostic tests. We saw training certificates that demonstrated that a Health Care Assistant (HCA) at the practice had been trained to carry out this service. When the demand for this service increased, we saw training records demonstrating that a second HCA had also been provided with training. One of the GPs informed us that they would be leaving the practice soon. There was an action plan in progress to recruit another salaried GP and a risk assessment had been completed identifying that locum GPs would be employed to cover any gaps in recruitment.

There were systems in place to deal with medical emergencies. We saw certificates demonstrating that staff were trained in cardiopulmonary resuscitation. Staff we spoke with accurately described the care they would provide to patients in the event of a medical emergency. There were emergency drugs, oxygen and emergency medical equipment for both adults and children available at the practice. The training records we looked at demonstrated that staff had received training in their use and staff confirmed that they had. There were systems in place to ensure that the emergency drugs and oxygen were in date and that the emergency equipment was fit for purpose.

Medicines Management

Medicines were stored safely. There were appropriate arrangements in place that ensured vaccines and temperature sensitive medicines were stored safely. We saw evidence that the temperature of the fridge used for storing these in was checked daily ensuring that they were stored within the manufacturer's guidelines. Staff accurately described to us the temperature range that medicines and vaccines should be stored at. Staff accurately described the actions they would take if the fridge temperature had not been maintained. There was a policy informing staff how to ensure the correct temperature range was maintained when flu vaccinations were taken out of the practice to be administered to patients in their own homes. Staff were aware of how to ensure the vaccines remained within the correct temperature ranges. Medications that did not require

Are services safe?

refrigeration were stored securely in a locked room and controlled drugs were stored appropriately. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Records also showed that the controlled drugs were recorded and checked appropriately.

There were systems in place to ensure vaccines were administered safely. There were up to date medicines management policies available to provide support and guidance to staff who delivered vaccines to patients. Staff we spoke with were aware of where to locate them if they needed to refer to them for advice. We saw that there were Patient Group Directives (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual prescriptions. Most of the PGDs had been signed by the nurses who administered the vaccines to demonstrate they had read the guidance and were safe to provide the vaccination to adults and children. The provider informed us that PGDs for all the vaccinations administered at the practice had been signed but we saw that seven were missing. The provider forwarded signed copies of the missing PGDs to us the next day.

Older patients were kept safe from receiving inappropriate medication. A medicines management audit had been completed for patients who were 75 years and above and on more than five medications a day. Where risks were identified, changes to their medication were made to ensure they did not continue taking medicines which may no longer be needed.

Cleanliness & Infection Control

There were systems in place to keep patients safe from the risk and spread of infection. There was an appropriate infection control policy available for staff to refer to. The policy identified the infection control lead for the practice. This meant staff were supported in reducing the risk of the spread of infection to patients. We saw that the infection control lead had received appropriate infection control training and they demonstrated a sound knowledge of the principals involved to prevent the spread of infection. Internal infection control audits had been carried out at the practice and where issues had been identified, appropriate action had been taken to make changes to protect patients from potential harm. On the day of our inspection the practice was clean and tidy. Patients we spoke with told us that the reception area and consulting rooms were always clean. They told us that when appropriate, staff wore personal protective equipment such as gloves and aprons. Staff confirmed personal protective equipment was readily available and we saw that it was. Hand sanitation gel was readily available for staff and patients throughout the practice.

The provider had taken reasonable steps to protect staff and patients from the risks of health care associated infections. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. There were guidelines informing staff what to do in the event of a needle stick injury and staff accurately described to us the actions they would take. Staff informed us, and we saw evidence, that they had received the relevant immunisations and support to manage the risks of health care associated infections.

Staffing & Recruitment

Effective recruitment and selection processes were in place to ensure staff were suitable to work at the practice. There was an up to date recruitment policy in place outlining the recruitment process to be followed in the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice. We saw that these checks had been carried out. These included Disclosure and Barring Service (DBS) checks for appropriate staff. When a DBS check had not been obtained for a staff member, a risk assessment had been completed to identify why this decision had been reached. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children. It replaced the Criminal Records Bureau (CRB).

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctor and nurses, were registered with their appropriate professional body and so fit to practice. There was a system in place that ensured health professionals' registrations were in date. There was a schedule in place that identified when professional registrations were due for renewal.

Dealing with Emergencies

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service. Service wide risk

assessments including fire, infection control and the risk of the legionella virus had been completed. There were systems in place to respond to emergencies and major incidents within the practice. There was a business continuity plan available which identified potential safety risks including changes in service demand, the disruption to staffing levels and loss of domestic services. The business continuity plan provided action plans and important contact numbers for staff to refer to. This meant that patients would continue to receive a service that was safe when potential safety risks had been identified

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as a defibrillator was available for use in a medical emergency. We saw that the equipment was checked weekly to ensure it was in working order and fit for purpose. In May 2014, portable appliance testing (PAT) had been carried out on all the electrical equipment at the practice. PAT testing ensured electrical equipment was safe to use when treating patients.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that the service was effective. Care and treatment was delivered in line with current published best practice achieving good outcomes for patients and promoting a good quality of life. Patients' needs were consistently met in a timely manner. The provider followed the Royal College of General Practitioners' clinical audit tool to assess the performance of its doctors. There was a comprehensive schedule of internal audits.

Our findings

Promoting Best Practice

Patients received care, treatment and support that achieved good outcomes and was based on the best available advice. The provider followed the National Institute for Health and Care Excellence (NICE) fast track guidelines for patients with symptoms of cancer. The aim of these guidelines is to help to increase the survival rate of patients with cancer. The provider informed us that the appropriateness of all referrals were discussed and peer reviewed at a weekly referral meeting. We saw minutes demonstrating NICE guidelines were also followed when supporting patients with a terminal illness to ensure that patients received continuity of care at the end of their life.

Mechanisms to seek, record and review consent decisions were implemented in line with relevant guidelines. When patients received minor surgery at the practice we saw that consent forms were signed demonstrating that patients understood the need and risks of the surgery. Patients who had received family planning treatment such as the insertion of a coil, signed consent forms. We saw these consent forms were in accordance with the Faculty of Sexual and Reproductive Healthcare as required by the Royal College of Obstetricians and Gynaecologists.

Some staff we spoke with had not received training in the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision regarding care and treatment based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Some staff we spoke with were not aware of the implications of this Act which meant that there was an increased risk that patients' best interest decisions may not always be considered when gaining consent.

Management, monitoring and improving outcomes for people

There was a comprehensive schedule of internal audits. We saw areas audited included infection control; appointments; medicines management; complaints and incidents. When changes to the service had been made, the provider used audits to monitor the outcomes for patients. For example, the provider identified there were insufficient emergency same day appointments for patients. This was because the duty doctor saw emergencies in addition to

Are services effective?

(for example, treatment is effective)

routine appointments. Changes were made to this system freeing one doctor per day to see emergencies only. When the provider audited the impact of this change, they found that the new system had created more same day emergency appointments for patients and helped to reduce delays in routine appointment times. We saw that the practice had a lower than national Accident and Emergency attendance rate because all patients who required an emergency appointment were seen on the day.

Improvements to clinical care were made because the provider followed the Royal College of General Practitioner's clinical audit tool to assess the performance of its doctors. One audit cycle of the use of the drug Tamoxifen (a drug used in the treatment of breast cancer) and selective serotonin reuptake inhibitors (drugs used to treat depression) had been carried out. Appropriate changes had been made when a need was identified. A second cycle of this audit was planned to ensure that the changes made had been effective in improving patient outcomes.

Staffing

There were effective induction programmes for new staff. The practice was a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine. There was a comprehensive induction programme in place that followed national guidelines to support new doctors into the practice. One of the doctors in training confirmed that they were well supported and had received an induction that met their needs.

The learning needs of staff were identified and training put in place to ensure patients received appropriate care and treatment. The provider maintained a training log for all staff which identified what mandatory training had been completed and when it was due to be updated. Where staff had identified the need for additional training, specific to their role or for their professional development, they had been supported to access this. Each month staff received additional training as outlined in a training schedule. We saw that this time was protected to enable all staff to attend.

There were systems in place that ensured appropriate levels of supervision and appraisal of all staff. All the staff we spoke with informed us that they received an annual appraisal which they found supportive and effective in helping them to identify and meet their learning needs. GPs were supported in their revalidation through an appraisal system. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date and fit to practise. Supervision of staff was provided on a one to one basis when needed and through structured meetings. These included; daily peer review between GPs: weekly meetings between the GPs and practice manager to discuss the general running of the service; monthly meetings between the GPs and the nursing team and monthly team meetings for all members of staff to attend.

Working with other services

There was proactive engagement with other health and social care providers to provide care that met patients' needs. We saw that doctors at the practice worked closely with the local district nursing team, palliative care nurses and social workers to provide care and support to patients with a terminal illness. A member of the Health Visiting team confirmed they worked closely with the safeguarding lead for children at the practice to ensure that children and their families were cared for effectively. A Health Visitor informed us they had raised concerns that they were not always informed when a new child registered with the practice. This meant that some children may not have received the care and support the Health Visiting service provided. The provider listened to the Health Visitor's concerns and amended their information sharing processes.

There were joint working arrangements allowing the practice to work with other services. These included a counsellor from 'Improving Access to Psychological Services' (IAPT) providing weekly support to patients with mental health problems; monthly continence advisors providing assessment and support for patients suffering from incontinence; weekly physiotherapy sessions; four to six weekly diabetic retinopathy clinics and three yearly breast screening.

Health Promotion & Prevention

The provider had systems in place to identify patients that may need additional support. The Warwickshire Area Health Profile identified that South Warwickshire is significantly worse than the national average in reducing the number of women smoking in pregnancy. To address this issue, two members of staff at the practice had been trained to deliver smoking cessation advice and support. They worked alongside the Warwickshire Stop Smoking Service project to help to improve health outcomes for the

Are services effective?

(for example, treatment is effective)

local population. Practice nurses carried out weekly vaccination sessions for children in line with the Healthy Child Programme. Literature was readily available for parents explaining the benefits of vaccination and the possible side effects. Parents we spoke with confirmed they were provided with information that met their needs. The provider had identified that the uptake of the flu vaccination had decreased especially for patients living in sheltered accommodation. To increase the accessibility of this service, the provider delivered flu vaccination sessions to patients living in a local residential caravan park and at two sheltered accommodation units. A Saturday morning 'commuters' clinic enabled patients in full time employment who found it difficult to access appointments during the week to be seen at a time more suitable for them.

Patients with learning difficulties were supported to access healthy living advice from the practice. The nurse practitioner had attended best practice training through Coventry and Warwickshire Partnership NHS Trust to help patients with learning difficulties achieve a healthier life style and manage their long term conditions effectively. Patients were invited for a review of their health by the use of an easy read invitation. Easy read management plans, such as epilepsy management and healthy eating, were available to help patients understand and manage their health in a way they understood. This service had recently been introduced into the practice and the provider was considering ways of expanding the service and reviewing the effectiveness of delivering care in this way.

Are services caring?

Summary of findings

We found that the service was caring. All the patients we spoke with told us that staff involved and treated them with compassion, kindness, dignity and respect. The providers own regular patient surveys produced consistently positive results.

Our findings

Respect, Dignity, Compassion & Empathy

Patients were treated with dignity and respect. The practice had an up to date dignity and respect policy and chaperone policy in place for staff to refer to for support and advice. Staff had received training in maintaining confidentiality and equality and diversity. There was a designated quiet room that staff took patients to if they required a confidential conversation with a member of staff. Staff were familiar with the steps they needed to take to protect patients' dignity. We saw that patient consultations took place in private rooms, behind closed doors, meaning they were private. Staff described to us the steps they took to protect a patient's dignity during a sensitive examination. Patients confirmed they felt staff and doctors had effectively protected their privacy and dignity.

Patients received compassionate care. The staff we spoke with all displayed a passion for patient care and were keen for the service to be patient centred. We saw that staff were kind and caring both on the telephone and face to face. One patient told us how a receptionist had comforted her when she became upset at the practice. Parents informed us that their children were treated with kindness and staff used age appropriate language to explain things to their children. One parent told us, "This is a great practice – I will be recommending my parents to join here when they move shortly".

Carers were supported to receive emotional support from suitably trained staff. There were carer identification and referral forms available at the reception desk for carers to complete and hand in to the practice if they required support. With the carer's permission, their details were forwarded to a countrywide Carer's Service and to the Adult Care Services for an assessment of their needs. One carer informed us that the practice had recently sent a referral to the Adult Care service on their behalf.

Involvement in decisions

Patients were involved in decisions about their care and treatment. We asked staff how they involved patients who had communication difficulties in the decisions about their care and treatment. Staff told us that they had access to a

Are services caring?

translation service if patients could not speak English, there were posters on display in the reception area informing patients of this. Staff also had access to interpreting services for patients with a hearing impairment.

The provider worked closely with the Patient Participation Group (PPG) to involve patients in the way that services were delivered. For example, the PPG had identified the need for patients to be able to identify the staff more easily. The provider had responded to this by putting named photographs of each member of staff on display in the reception area. This meant that the provider had taken reasonable action to enable patients to become more aware of the roles and responsibilities of the different members of staff who worked at the practice. Individual patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. One patient confirmed that the GP always returned their call when they asked them to. Patients were satisfied with the level of information they had been given and said they felt supported and informed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the service was responsive because services were organised to meet the needs of patients. There was an open culture within the organisation and a clear complaints policy. Patient suggestions for improving the service were acted upon. The provider participated actively in discussions with commissioners about how to improve services for patients in the area.

Our findings

Responding to and meeting patients' needs

The provider understood the different needs of the population it served and acted on these to design services. There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a wheelchair available for patients with mobility problems and a disabled parking space. There was a disabled toilet but chairs in front of the toilet made access for wheelchair users difficult. The provider removed the chairs on the day of our inspection.

The practice had a high elderly population. The practice responded to this need by providing care such as the delivery of flu vaccines within the local community. A phlebotomy service had been established at the practice to increase the accessibility of this service to the elderly and less mobile. Patients with long term chronic conditions, such as diabetes and asthma, received regular checks by appropriately trained nurses and health care assistants. There were clinical leads for each type of long term chronic disease ensuring that GPs maintained a specialist interest in this field of medicine. This meant that patients and staff had pathways to access within the practice to obtain the support they required. There were systems in place to support children, families and patients in vulnerable circumstances. Visiting professionals confirmed that the provider was proactive in responding to their needs.

Access to the service

The appointment system supported choice and enabled patients to access the right care at the right time. Patients could access appointments on-line by the practice website, by telephone or face to face in the surgery. Patients could book appointments up to six weeks in advance which meant they were assessed by a GP in a timely way which met their needs. The appointments system was closely monitored and in response to a recent appointments audit, access to emergency appointments had recently changed to meet patients' demands. A nurse practitioner had been put in place to triage appointments three days a week and there was a duty doctor covering emergency appointments each day. Home visits were accommodated when required and patients told us it was never a problem if they required

Are services responsive to people's needs?

(for example, to feedback?)

a home visit. The appointments audit identified that the late night surgery for working patients was not being utilised appropriately. The service was moved to a Saturday morning and appointments were protected for patients in full time employment and found it difficult to access appointments in the week.

The provider had audited the number of patients who failed to attend for their appointments. In response to this, the provider shared this information with patients to raise their awareness of the impact this had on the availability of appointments. A follow up audit demonstrated that the number of wasted appointments were reduced so improving the accessibility of appointments for patients. Patients were made aware of how to access out-of-hours services by the practice website, the patient leaflet and a telephone message on the practice telephone.

Concerns & Complaints

Staff told us that there was an open and transparent culture in place and their concerns were listened to by the provider. One member of staff told us, "It's because you get listened to that you don't mind speaking out". We saw that there was a robust complaints procedure in place and that the provider audited the complaints making changes to the service when a need was identified. Learning points were shared with the whole team at team meetings and staff confirmed this.

The practice had an active and engaged PPG. We spoke with a spokesperson from the PPG who told us that the practice manager and GPs actively engaged with the group. The PPG along with the provider had conducted regular patient surveys and where appropriate, responded to the issues raised. For example, the survey demonstrated there was limited awareness amongst patients regarding the ability to book appointments on-line. The PPG spokesperson confirmed that the provider had supported the PPG in promoting this facility.

Are services well-led?

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

Summary of findings

We found that the service was well led. The leadership, management and governance of the practice assured the delivery of high-quality care, supported learning and innovation and promoted an open and fair culture.

Our findings

Leadership & Culture

There was a vision to deliver high quality care and promote good health outcomes for patients. This was documented in the practice's statement of purpose which was located on the internal computer system. A summary of this was available in the patient practice leaflet. There was an established management structure which identified key roles and clinical leads. We saw that an accountable staff member was named within each policy. Each member of staff demonstrated a deep understanding of their area of responsibility and other staff at the practice were able to articulate who key clinical and non-clinical leads were. We saw that there was a positive relationship between clinical and non-clinical staff. Staff described the culture within the organisation as supportive and inclusive with a focus on patient care. Staff also told us that the leadership was visible and accessible.

Governance Arrangements

The provider ensured that any risks to the delivery of high quality care were identified and addressed before they impacted on the quality of care patients received. This included risk assessments such as fire, legionella virus and infection control. Action plans were put in place when risks were identified. There was a business continuity plan to ensure disasters such as loss of domestic services, flooding or loss of information technology did not affect the delivery of a safe and effective service to patients.

There were processes in place to provide systematic assurance that high quality care was being delivered. The provider worked closely with the Clinical Commissioning Group (CCG) by responding to feedback they provided and making local arrangements at practice level to improve care and treatment where needed. For example, CCG feedback identified a high hospital orthopaedic and ophthalmology referral rate by the practice. In response to this, we saw evidence that weekly referral meetings were held between the GPs at the practice to ensure the appropriateness of the referrals.

Systems to monitor and improve quality & improvement

There was a comprehensive schedule of internal audits. Areas audited included infection control; appointments; medicines management; complaints and incidents. Improvements to clinical care were made because the

Are services well-led?

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

provider followed the Royal College of General Practitioner's clinical audit tool to assess the performance of its doctors. One audit cycle of the use of the drug Tamoxifen (a drug used in the treatment of breast cancer) and selective serotonin reuptake inhibitors (drugs used to treat depression) had been carried out. Appropriate changes had been made when a need was identified. A second cycle of this audit was planned to ensure that the changes made had been effective in improving patient outcomes.

Patient Experience & Involvement

The provider recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, patient surveys and working in partnership with the Patient Participation Group (PPG). Results of patients' surveys and PPG comments were shared with patients through the practice website and within a folder at the practice. We saw that an action plan had been developed and all the actions identified had been addressed by the provider.

Staff engagement, involvement and learning

Feedback and comments by staff were encouraged, listened to and acted upon. The provider actively encouraged the participation and involvement of staff through annual appraisals. The team at Henley-in-Arden Medical Centre worked together to address and resolve problems in the delivery of high quality care. Staff away days encouraged the whole team to reflect and consider the systems currently in place at the practice, if the systems were working to their full potential and to offer solutions if not. For example, staff identified that the system for patients to book appointments six weeks in advance was difficult to manage when a GP gave less than six weeks' notice of annual leave. Staff felt confident to raise their concerns at the away day and a new system had been implemented requiring GPs to give at least six weeks' notice before taking annual leave. This helped patients to access their GP of choice.

Identification & Management of Risk

The provider had produced a comprehensive list of potential risks to its service. The risks identified were assessed and rated within the practice's business continuity plan. Where there were specific groups of patients considered to be at risk, a clinical lead had been identified to ensure lines of accountability. There was a safeguarding lead for safeguarding, chronic disease management, infection control and patients with mental health problems. The provider, practice manager and the GPs we spoke with informed us that risks and their management were discussed at a weekly business meeting.

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

Older patients were safe because the provider monitored the safety of older patients and responded to the risks identified. They received an effective service receiving care, treatment and support that achieved good outcomes and was based on best practice. Older patients received compassionate care which was responsive to their needs. Services for older patients were well led because the provider worked closely with the CCG responding to feedback and making arrangements at practice level to improve care and treatment where needed.

Our findings

Safe

Older patients at Henley-in-Arden Medical Centre were kept safe. The provider monitored the safety of older patients and responded to the risks identified. The provider identified there was poor access to phlebotomy services because elderly patients were required to travel a distance to have their blood taken for diagnostic tests. The provider responded to the risk of patients failing to have their bloods tests carried out by training two health care assistants to carry out this service at the practice. There were systems in place that ensured elderly patients received flu, pneumococcal and shingles vaccinations that were stored appropriately and administered by appropriately trained staff. A medicines management audit had been completed for patients who were aged 75 and above and on more than five medications a day. Where risks were identified, changes to their medication were made to ensure they did not continue taking medicines which they no longer needed.

Effective

Older patients received care, treatment and support that achieved good outcomes and was based on the best practice. The provider followed the National Institute for Health and Care Excellence (NICE) fast track guidelines for patients with symptoms of cancer. The aim of these guidelines is to help to increase the survival rate of patients with cancer. The appropriateness of all referrals were discussed and peer reviewed at a weekly referral meeting. The provider proactively identified older patients who needed additional support to access vaccination programmes. They identified that the uptake of the flu vaccination had decreased especially for patients living in sheltered accommodation. To increase the accessibility of this service, the provider delivered flu vaccinations to older patients living in a local residential caravan park and at two sheltered accommodation units.

Caring

Older patients received compassionate care. The staff we spoke with all displayed a passion for patient care and

Older people

were keen for the service to be patient centred. We saw that staff were kind and caring both on the telephone and face to face. An older patient told us how a receptionist had comforted her when she became upset at the practice.

Responsive

The provider was responsive to the needs of older patients. The practice had a high elderly population. The practice responded to this by providing medical care within a local care home and the delivery of flu vaccines at a residential caravan park and sheltered housing unit. A phlebotomy service had been established at the practice to increase the accessibility of this service to the elderly and less mobile.

Well led

The provider worked closely with the CCG by responding to feedback they provided and making local arrangements at practice level to improve care and treatment where needed. For example, CCG feedback identified a high hospital orthopaedic and ophthalmology referral rate by the practice. In response to this, we saw evidence that weekly referral meetings were held between the GPs at the practice to ensure the appropriateness of the referrals.

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

Patients with long term conditions were safe because the provider provided annual checks following NICE guidance to ensure patients received appropriate care. Patients received an effective service that met their needs by working in partnership with other services. Patients received compassionate care which was responsive to their needs. Services for patients with long term conditions were well led because there was a clear vision to deliver high quality care and promote good health outcomes for patients.

Our findings

Safe

Patients with long term conditions were kept safe. Annual checks were carried out by GPs and nurses for patients with long term conditions including; diabetes; coronary heart disease; chronic obstructive pulmonary disease (COPD); high blood pressure; asthma and thyroid problems. Staff informed us they followed NICE guidance to ensure that patients received the most appropriate care. Leaflets were available for patients with long term conditions and patients told us they were sign-posted to information available on the internet. An automatic recall system within the practice computer system ensured that patients who failed to attend for their annual check were identified. If a patient had failed to attend for their appointment a follow up letter was sent to remind them of the importance of these checks.

Effective

Patients with long term conditions received an effective service. The provider worked with other services to provide care that met the needs of patients with long term conditions. For example, every four to six weeks a diabetic retinopathy clinic was held at the practice to help to reduce the risk of vision loss in patients with diabetes.

Caring

Patients with long term conditions told us that they received compassionate care. They told us they were well supported by the whole team at the practice and could speak to GPs if they had any concerns regarding their or their relative's long term condition. A carer for a patient with a long term condition told us that it was never a problem when they required a home visit from a GP.

Responsive

The provider understood the different needs of the population it served and acted on these to design services. There were arrangements to ensure that care and

People with long term conditions

treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a wheelchair available for patients with mobility problems and a disabled parking space. There was a disabled toilet but chairs in front of the toilet made access for wheelchair users difficult. The provider removed the chairs on the day of our inspection.

Well led

There was a vision to deliver high quality care and promote good health outcomes for patients. This was documented in the practice's statement of purpose. There was an established management structure which identified key roles and a clinical lead for patients with long term conditions. This meant that it was clear who was responsible for making specific decisions about the provisions of services for patients with long term conditions.

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

Mothers and their children received a service that was safe because there were systems in place to protect children from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. They received an effective service that met their needs by working in partnership with other services. Patients received compassionate care which was responsive to their needs. Services for mothers and their children were well led because there was a clear vision to deliver high quality care and promote good health outcomes for patients.

Our findings

Safe

Children were kept safe because the provider had taken reasonable steps to embed safeguarding systems within their practice to protect children from harm. Staff had received training in safeguarding children and were aware of what they would do if they suspected a child was at risk of abuse. There were up to date policies in place for safeguarding children which clearly identified a children's safeguarding lead within the practice. The policies contained information to support staff in recognising and reporting safeguarding concerns to the appropriate agencies for investigation. Disclosure and Barring Service checks had been undertaken before staff began to work at the practice to ensure staff were suitable to work with children. The provider worked with other services to prevent abuse and to implement plans of care. We spoke with a Health Visitor on the day of our inspection. They told us that they had weekly face to face meetings with the designated safeguarding lead for children to discuss how to manage and support children and families in vulnerable situations. They gave us examples of when they had worked with the GP to support children in vulnerable circumstances.

Children were kept safe from avoidable infectious diseases. Children received childhood vaccinations in line with the national NHS vaccination schedule and the Health Child Programme. Vaccines were stored safely and in line with the manufacturer's guidelines. They were administered safely because staff were trained appropriately and had signed patient group directives (PGD) demonstrating they had read the guidance and were safe to provide childhood vaccinations to children.

Effective

Mothers and children received an effective service. Mechanisms to seek, record and review consent decisions were implemented in line with relevant guidelines. Patients who had received family planning treatment such as the

insertion of a coil, signed consent forms. We saw these consent forms were in accordance with the Faculty of Sexual and Reproductive Healthcare as required by the Royal College of Obstetricians and Gynaecologists. Parents told us that they were fully informed of the benefits and risks of their children receiving childhood immunisations and felt that they were able to provide informed consent for the immunisation to be administered. The provider had systems in place to identify patients that may need additional support. The Warwickshire Area Health profile identified that South Warwickshire is significantly worse than the national average in reducing the number of women smoking in pregnancy. To address this issue, two members of staff at the practice had been trained to deliver smoking cessation advice and support. They worked alongside the Warwickshire Stop Smoking Service project to help to improve health outcomes for the local population. Pregnant women who smoked were also referred to South Warwickshire NHS Trust for more specialist support during their pregnancy.

The practice worked with other services, listening to their concerns and making changes when required. A Health Visitor informed us they had raised concerns with the provider that they were not always informed when a new child registered with the practice. This meant there was an increased risk of children not receiving the care and support they may require from the Health Visiting service. The Health Visitor informed us that the provider listened to their concerns and had amended their information sharing processes so they received this information in a timely manner and were able to provide appropriate support to children and their families.

Caring

Parents informed us that their children were treated with kindness and staff used age appropriate language to explain things to their children. One parent told us, "This is a great practice – I will be recommending my parents to join here when they move shortly".

Responsive

The service was responsive to the needs of children. The appointment system supported choice and enabled patients to access the right care at the right time. Patients could access appointments on-line by the practice website, by telephone or face to face in the surgery. Patients could book appointments up to six weeks in advance which meant they were assessed by a GP in a timely way which met their needs. The provider informed us that children were treated as a priority group and were always offered an on the day emergency appointment if requested. Parents we spoke with confirmed that they had been provided with on the day appointments for their child when they had requested one.

Well led

There was a vision to deliver high quality care and promote good health outcomes for patients. This was documented in the practice's statement of purpose. There was an established management structure which identified the clinical lead for safeguarding children. This meant that it was clear who the responsible person was to ensure that systems within the practice supported the prevention of abuse of children.

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

Working age patients were kept safe because there were screening services to enable the early detection and treatment of some cancers. They received an effective service because improvements to clinical care were made following a clinical audit. Patients received compassionate care which was responsive to their needs. Services for working age patients were well led because the provider worked closely with the CCG by responding to feedback they provided and making local arrangements at practice level to improve care and treatment where needed.

Our findings

Safe

Working age patients were kept safe. Patients aged 40 years and above were offered well person checks at the practice to identify any health problems and promote a healthy life style. Women aged 25 and above were offered three yearly cervical screening and women aged 50 years and above were offered screening every five years. The breast screening service visited the practice every three years. This meant that patients were provided with screening services to enable the early detection and treatment of some types of cancer.

Effective

Working age patients received an effective service. There were systems in place to manage, monitor and improve the outcomes for working age patients. Improvements to clinical care were made because the provider followed the Royal College of General Practitioner's clinical audit tool to assess the performance of its doctors. One audit cycle of the use of the drug Tamoxifen (a drug used in the treatment of breast cancer) and selective serotonin reuptake inhibitors (drugs used to treat depression) had been carried out. Appropriate changes had been made when a need was identified. A second cycle of this audit was planned to ensure that the changes made had been effective in improving patient outcomes.

Through an appointments audit, the provider proactively identified the need to provide appointments that met the needs of working aged patients. A Saturday morning 'commuters' clinic was introduced at the practice. This meant that patients in full time employment who found it difficult to access appointments during the week could be seen at a time more suitable for them.

Caring

Working age patients told us they were involved in decisions about their care. The provider worked closely with the PPG to involve patients in the way that services were delivered. For example, the PPG had identified the need for patients to be able to identify the staff more easily.

Working age people (and those recently retired)

The provider had responded to this by putting named photographs of each member of staff on display in the reception area. Individual patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions.

Responsive

The service was responsive to the needs of working patients accessing appointments. An appointments audit identified that the late night surgery for working patients was not being utilised appropriately. The service was moved to a Saturday morning and appointments were protected for patients in full time employment who found it difficult to access appointments in the week.

Well led

The provider worked closely with the CCG by responding to feedback they provided and making local arrangements at practice level to improve care and treatment where needed. For example, CCG feedback identified a high hospital orthopaedic and ophthalmology referral rate by the practice. In response to this, we saw evidence that weekly referral meetings were held between the GPs at the practice to ensure the appropriateness of the referrals.

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

Patients in vulnerable circumstances received a service that was safe because there were systems in place to protect vulnerable adults from abuse and avoidable harm. There was a strong focus on openness and transparency internally and externally when things went wrong. They received an effective service that met their needs by working in partnership with other services however not all staff were aware of the implications of the Mental Capacity Act 2005 when gaining consent from patients who may lack capacity to make informed decisions. Patients received compassionate care which was responsive to their needs. Services for patients in vulnerable circumstances were well led because there was an established management structure which clearly identified the clinical lead for safeguarding vulnerable adults.

Our findings

Safe

Vulnerable adults were kept safe because the provider had taken reasonable steps to embed safeguarding systems within their practice to protect them from abuse. Staff had been trained in safeguarding vulnerable adults and were aware of what they would do if they suspected anyone was at risk of abuse. There were up to date policies in place for safeguarding vulnerable adults which clearly identified a vulnerable adult's safeguarding lead within the practice. The policies contained information to support staff in recognising and reporting safeguarding concerns to the appropriate agencies for investigation. Disclosure and Barring Service checks had been undertaken before staff began to work at the practice to ensure staff were suitable to work with vulnerable adults.

The provider worked with other services to prevent abuse and to implement plans of care. We spoke with a visiting professional on the day of our inspection. They gave us examples of when they had worked with a GP to support patients experiencing domestic abuse. We saw that there were posters displayed informing patients where they could gain help and support if they were a victim of domestic abuse.

Effective

Vulnerable patients received an effective service. The provider worked with other services to proactively engage with other health and social care providers to provide care that met the needs of patients with a terminal illness. We saw that doctors at the practice met with and worked closely with the local district nursing team, palliative care nurses and social workers to provide care and support to patients with a terminal illness. This meant that patients received continuity of care at the end of their life.

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

Patients with learning difficulties were supported to access healthy living advice from the practice. The nurse practitioner had attended best practice training through Coventry and Warwickshire Partnership NHS Trust to help patients with learning difficulties achieve a healthier life style and manage their long term conditions effectively. Patients were invited for a review of their health by the use of an easy read invitation. Easy read management plans, such as epilepsy management and healthy eating, were available to help patients understand and manage their health in a way they understood. This service had recently been introduced into the practice and the provider was considering ways of expanding the service and reviewing the effectiveness of delivering care in this way.

Vulnerable patients received an effective service. However, the provider could not be sure that patients who lacked capacity were supported appropriately to make informed decisions. Mechanisms to seek and record consent decisions were implemented in line with relevant guidelines although not all staff had received training in the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision regarding care and treatment based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Some staff we spoke with were not aware of the implications of this Act which meant that patients' best interest decisions may not always be considered when gaining consent.

Caring

Vulnerable patients were treated with dignity and respect. The practice had an up to date chaperone policy in place for staff to refer to for support and advice. Staff were familiar with the steps they needed to take to protect patient's dignity during a sensitive examination. We saw consultations took place in private consultation rooms, behind closed doors, meaning they were private. Patients confirmed they felt staff and doctors had effectively protected their privacy and dignity.

Patients were involved in decisions about their care and treatment. We asked staff how they involved patients who had communication difficulties in the decisions about their care and treatment. Staff told us that they had access to a translation service if patients could not speak English, there were posters on display in the reception area informing patients of this. Staff also had access to interpreting services for patients with a hearing impairment.

Responsive

The service was responsive to the needs of patients with a terminal illness. There was a register of terminally ill patients receiving end of life care. The provider and the reception staff told us that patients receiving end of life care were always provided with priority appointments at a time and location that met their needs.

Well led

There was an established management structure which clearly identified the clinical lead for safeguarding vulnerable adults. This made it clear who the responsible person was to ensure that systems within the practice supported the prevention of abuse of vulnerable adults.

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

Patients experiencing poor mental health received a service that was safe and effective because the provider worked with other services to identify risks to patients. Patients received compassionate care which was responsive to their needs. Services for patients experiencing poor mental health were well led because risks identified were assessed and action plans to manage the risks were available within the practice's business continuity plan.

Our findings

Safe

Patients with mental health problems were kept safe. We spoke with a visiting professional on the day of our inspection. They gave us examples of when they had worked with a GP to support women with postnatal depression. When a patient had been identified by either the visiting professional or a GP and had given their consent, the GP worked in partnership with the professional to provide care and support to keep the patient safe from the risks associated with postnatal depression. This included anti-depressant medication, listening visits, counselling and referral to specialist services.

Effective

Patients with mental health problems received an effective service. There were joint working arrangements allowing the practice to work with other services. These included a counsellor from 'Improving Access to Psychological Services' (IAPT) providing weekly support to patients with mental health problems. This meant that the provider worked in partnership with mental health services providing care that was easily accessible to patients with mental health problems.

Caring

Carers of patients were supported to receive emotional support from suitably trained staff. There were carer identification and referral forms available at the reception desk for carers to complete and hand in to the practice if they required support. With the carer's permission, their details were forwarded to a countrywide Carer's Service and to the Adult Care Services for an assessment of their needs. One carer informed us that the practice had recently sent a referral to the Adult Care service on their behalf.

People experiencing poor mental health

Responsive

There was a clinical lead at the practice responsible for the care and treatment of patients experiencing poor mental health. Where the practice was not able to meet the needs of patients with poor mental health it worked with other services such as IAPT to ensure their needs were met.

Well led

There were systems in place for the identification and management of risk for patients with poor mental health.

The provider had produced a comprehensive list of potential risks to its service. The risks identified were assessed and rated within the practice's business continuity plan. Where there were specific groups of patients considered to be at risk, for example patients with poor mental health, a clinical lead had been identified to ensure lines of accountability.