Owen Road Surgery

Quality Report

67 Owen Road, Skerton, Lancaster.
LA1 2LG
Tel: 01524 846999
Website: www.owenroad.com

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Owen Road Surgery on 01 October 2014.

We inspected this practice as part of our new focused, comprehensive, inspection programme. This practice had previously been inspected using our old methodology.

During our visit we spoke with staff including GPs, receptionists, health care assistants, administration staff, and nurses. Following our inspection we spoke with six patients. Those patients we spoke with, and who completed the 13 Care Quality Commission comment cards, were all extremely complimentary about the care and treatment provided at the practice. Patients reported that all staff treated them with dignity and respect.

We looked at how well the practice provided services for specific groups of patients. These included; older patients, patients with long-term conditions, families, children and young people, working age patients (including those recently retired and students), patients living in vulnerable circumstances and patients experiencing poor mental health.

We found that the practice met the regulations and provided services that were safe, effective, caring, responsive and well led.

The overall rating for this practice was good.

Our key findings were as follows:

- The practice provided an effective service for all age groups. GPs, apart from having the overall competence to assess each person attending the service, had particular interest areas. For example, one GP worked collaboratively with the local hospice and was the practice lead for palliative care.
- Patients confirmed they were able to contact the practice and speak with a health practitioner in a timely and accessible manner. Patients told us they could always get an appointment when they needed one, including on the same day if it was urgent.

Summary of findings

- The practice ran a personal list system which meant that patients were registered with a particular GP. Staff knew patients and their needs well. Patients commented on the caring and friendly nature of the staff team.
- The practice took time to listen to the views of their patients and ran an active Patient Participation Group. Actions were identified to improve the service.
- Systems were in place within the practice to provide oversight of safety of the patients and environment. Patients told us the practice was always clean.

We saw areas of outstanding practice:

- The practice held weekly meeting to discuss which patients had recently passed away. Bereaved families were visited at home to offer emotional support and to sign post to other services.
- The practice ran appointments in conjunction with Inspire (drug and alcohol service) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

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

- Ensure fridges used to store vaccines are hardwired. This is according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.
- If non clinical staff provide chaperone services they should be suitably trained.
  - However, there were also areas of practice where the provider should make improvements.

- Ensure fridges used to store vaccines are hardwired. This is according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.
- If non clinical staff provide chaperone services they should be suitably trained.
  - Some policies, including whistleblowing and recruitment required updating to reflect current guidelines.

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

- Fridges used to store vaccines should be hardwired. This is according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.
- If non clinical staff provide chaperone services they should be suitably trained.
- Some policies, including whistleblowing and recruitment required updating to reflect current guidelines.

- Include Mental Capacity Act (2005) and "best interests" decisions training for staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was safe. Information from NHS England and the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. Two GPs took the position of safeguarding lead and deputy. Staff were knowledgeable about what constituted a safeguarding concern and knew which agency to refer to.

Systems were in place to provide oversight of safety of the patients and environment. Staff took action to learn from any incidents that occurred within the practice.

Are services effective?

Good

The practice was effective. Care and treatment was delivered in line with current published best practice. The team used staff meetings and audits to assess how well they delivered the service.

The practice was a teaching practice and supported trainee GPs. GPs told us this encouraged discussion of new best practice guidelines. Annual staff appraisals were offered to staff to review performance and identify training or development needs for the coming year.

Are services caring?

Good

The service was caring. We received 13 CQC comment cards and spoke with 6 patients. Patients were very positive about the care they received at the practice. They commented on the friendliness of the staff team and the competence of the GPs and nurses.

The practice was aware of the importance of providing patients with privacy. A separate room was available for patients to speak to staff away from the reception desk.

The national GP survey results published in 2013 found that 93% of patients said the last time they saw or spoke to their GP the GP was good at treating them with care and concern.

Are services responsive to people's needs?

Good

The service was responsive. The practice made adjustments to meet the needs of patients, including having a portable audio loop system for patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was not their first language.

Summary of findings

The practice was responsive to patient feedback. The practice had an active patient participation group (PPG). The practice had a complaints policy which provided staff with clear guidance on how to handle a complaint and we saw the documentation to record the details of any concerns raised and action taken.

Are services well-led?

Good

The service was well-led. The practice had a clear vision and set of values which were displayed by staff and included a commitment to involving patients in their own healthcare and in developing services.

GPs, clinical staff and the practice manager led on the individual aspects of governance such as complaints and audits within the practice. Clinical audits were carried out following significant events, complaints and as a result of national alerts or local prescribing initiatives.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

The practice had begun to make efforts to engage more with a local care home. We saw that a meeting was scheduled to take pace.

The practice had a register of all patients in need of palliative care, which included a high proportion of older patients. A regular monthly palliative care meeting was held to discuss the patients on the palliative register and to consider if any additional support was required.

People with long term conditions

Good

The practice was knowledgeable about the number and overall health needs of patients with long term conditions using the service. They worked with other health services and agencies to provide appropriate support.

We saw that clinical audits were completed and where appropriate, any actions following the findings implemented and reviewed. For example, an audit was conducted of patients who were diagnosed as having high risk Atrial Fibrillation and were prescribed anticoagulants. Atrial fibrillation is a heart condition which causes an irregular and often abnormally fast heart rate. Clear learning points were identified and implemented. We saw evidence that this audit had directly improved the outcomes for these patients.

Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. Individual staff who had had specialist training were responsible for specific areas of care.

Families, children and young people

Good

The practice provided services to meet the needs of this population group. There were comprehensive screening and vaccination programmes which were managed effectively to support patients. Community midwives attended the surgery four days per week, one of which was a drop in session to encourage attendance.

Summary of findings

Staff were knowledgeable about child protection and two GP's took the lead and deputy lead for safeguarding. The practice monitored any non-attendance of babies and children at vaccination clinics and worked closely with the health visiting service to follow up any concerns.

Working age people (including those recently retired and students)

Good

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations.

Patients were able to book a consultation with a GP through the extended hour's service. This was available until 7.45pm on Wednesday and Thursday. Each patient we spoke to was happy that they could see a GP or nurse when they needed to.

People whose circumstances may make them vulnerable

Outstanding

Staff were knowledgeable about safeguarding vulnerable adults and children. They had access to the practice's policy and procedures and had received training in the last 12 months.

The practice held appointments in conjunction with inspire (drug and alcohol service) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

The practice made adjustments to how they provided the service in order to meet patients' needs. The practice maintained a register of patients aged 18 and over with learning disabilities and we saw that patients were invited to attend annual health check reviews. The practice offered longer appointment times for patients with a learning disability and for annual health checks. This helped to ensure patients were given time to be fully involved in making decisions about their health.

Patients who were identified as vulnerable had access to a direct contact number for the practice and care plans had been developed with their involvement.

People experiencing poor mental health (including people with dementia)

Good

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a review of medicines.

Summary of findings

Community Mental Health Nurses provided clinics in the practice to facilitate easier access and engagement with patients.

Staff at the practice knew how to refer to Help Direct. Help Direct is a support and information service for adults that assists people with a wide range of issues. We were told that this might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement. Help Direct had recently attended the practice during flu clinics in order to promote their service.

Summary of findings

What people who use the service say

We received 13 CQC comment cards. Each comment card gave positive feedback about the practice, ranging from high quality of care to the friendliness of the staff team. Two comments were made about struggling to get through on the appointment line, however one person did say this had recently improved.

The national GP survey results published in 2013 found that 93% of patients said the last time they saw or spoke to their GP the GP was good at treating them with care and concern.

We spoke with six patients who were all extremely positive about the care and treatment they receive at the practice. Patients commented that they felt listened to and were treated with respect by both the reception staff and clinical staff.

Areas for improvement

Action the service SHOULD take to improve

Ensure fridges used to store vaccines are hardwired. This is according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.

If non clinical staff provide chaperone services they should be suitably trained.

Some policies, including whistleblowing and recruitment required updating to reflect current guidelines.

Include Mental Capacity Act (2005) and "best interests" decisions training for staff.

Outstanding practice

The practice held weekly meeting to discuss which patients had recently passed away. Bereaved families were visited at home to offer emotional support and to sign post to other services.

The practice ran appointments in conjunction with Inspire (drug and alcohol service) specifically for people with drug or alcohol problems. This encouraged people living chaotic lifestyles to attend the practice for health care and treatment.

Owen Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice manager specialist advisor.

Background to Owen Road Surgery

Owen Road Surgery provides a service to 9000 patients in the North Lancashire area and is part of NHS Lancashire North Clinical Commissioning Group.

Public Health England figures show that 22.94% of all patients at Owen Road Surgery are under 18 years of age or over and the largest percentage of the practice population. 59% of adults are of working status either paid work or in full-time education.

The practice is registered to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, surgical procedures, and treatment of disease, disorder or injury.

The practice is open Monday to Friday between 8am and 6.30pm. The practice also operates extended opening hours on Wednesday and Thursday until 7.45pm.

When the practice is closed and in the out of hours (OOH) periods patients are requested to contact either 999 for emergencies or telephone 111 for the OOH triage service provided by Bay Urgent Care. This information is available on the practice answerphone system and practice website.

The practice has 5 GP partners, four male and one female, one salaried GP, one Nurse Practitioner partner, one Practice Nurse, and two Healthcare Assistants and a pharmacist. The practice also has a practice manager and deputy practice manager and all are supported by administration, reception and secretarial staff.

The practice rarely use locum GPs, but when required the same locum is accessed if possible, for continuity of service for their patients.

GP partners have their professional details available for patients to read on the practice website. Clinics for specific conditions are held by the practice on a regular basis.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had previously been inspected under our old methodology.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 01 October 2014. During our visit we spoke with a range of staff and, following the inspection, spoke with patients who used the service. We reviewed 13 CQC comment cards where patients shared their views and experiences of the service.

We saw that staff spoke with patients in a friendly yet professional manner. We observed how patients accessed the service and how practice information was communicated. We reviewed a variety of documents used by the practice to assist in the smooth running of the service.

Good

Are services safe?

Our findings

Safe Track Record

Information from NHS England and the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety.

The practice held a central log of significant events and the changes made as a result of investigating these. It was clear in most cases identified actions had led to improvements in order to reduce the risk of the event reoccurring. We saw incidents had been analysed to consider what had occurred and why, what lessons had been learnt and whether there were measures that could be put in place to prevent future recurrence or improve care. Staff told us that significant events were discussed at staff meetings and there was an open and transparent environment which encouraged staff to report any concerns.

There were mechanisms in place using different information sources to ensure a shared awareness of key risks with all staff. For example, systems were in place to promptly manage national patient safety alerts in order to protect patients. GPs received alerts by email. The practice pharmacist also produced and circulated an analysis of any alerts received relating to medicines.

We saw that that any complaints once investigated were analysed, summarised and reviewed to observe for trends or recurrent risks.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. Staff told us that they were encouraged to report incidents and this was seen as a positive way to ensure they provided a high standard of patient care.

Safety alerts from Medicines and Healthcare products Regulatory Agency (MHRA) and other sources were monitored and shared with clinical staff via the internal email system and acted upon as necessary.

We found that with changes to national guidelines, practitioner's guidance and any medicines alerts were discussed and actioned. Staff met on a regular basis through a variety of clinical and non clinical meetings. This information sharing meant the GPs, nurses and non-clinical staff were confident that the treatment approaches adopted followed best practice.

We saw that these meetings were minuted. This meant the potential of misinformation, misunderstanding or error was reduced.

Reliable safety systems and processes including safeguarding

Staff we spoke with were knowledgeable about child and adult safeguarding and the relevant practice policies in place. A hard copy of the local authority referral pathway and contact details were available in all treatment and consulting rooms and behind reception.

The practice had procedures in place for managing and dealing with safeguarding children. The Staff we spoke with had a good understanding of safeguarding and told us how information was recorded on patient notes if a safeguarding concern was raised about a child.

The practice had a named GP and a deputy, who took the lead role in safeguarding adults and children. Staff had received training in safeguarding vulnerable adults and children which was appropriate to their roles.

Staff were proactive in monitoring children who frequently missed appointments. These children were brought to the attention of the GP or practice nurse who worked closely with other health professionals such as the health visitor. We spoke to the community midwife who praised the level of communication with the practice.

Staff we spoke with understood what was meant by the term "Whistleblowing" and the practice had a policy in place. This meant there were processes in place to assist staff to expose poor care or bad practice. However, staff were unaware that they could contact the Care Quality Commission about such concerns and this was not mentioned in the practice policy.

Notices were displayed in the practice advising patients they could have a chaperone present during their consultation if they wished. We were told that clinical staff were used to act as chaperones. However, there had been occasions where non clinical staff who had not been trained had provided this service when nurses were not available.

Good

Are services safe?

Each consultation and treatment room had access to a computer alert system which could be used to request assistance in an emergency. Staff we spoke with who had used this system told us it worked well.

We saw documentary evidence the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. All staff had completed training on fire safety as part of their induction with further annual reviews and they were aware who the practice fire marshal was.

Medicines Management

Medicines reviews were conducted by GPs or the practice pharmacist. The practice regularly checked patients receiving repeat prescriptions had at least an annual medicine review. For patients with long-term conditions, such as diabetes, there was a system in place to ensure regular health checks took place.

The medicines fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed and rotated.

We found that the vaccine fridges were not hardwired which is considered to be best practice according to NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014. Fridges which are hardwired directly rather than having a conventional plug reduce the risk of the fridge losing power.

Oxygen was stored in the reception in a staff only area. We saw that staff could access the oxygen and the cylinder was full, in date and ready for use.

Cleanliness & Infection Control

We found the practice to be clean and tidy, patients we spoke with confirmed this was always the case.

Staff told us that infection control and prevention was covered in their induction and we saw evidence that training was offered on a three yearly basis thereafter.

There was a waste collection contract in place to collect clinical waste on a weekly basis.

Personal protective equipment (PPE), such as aprons and gloves, was available in all treatment rooms. Staff we spoke with told us these supplies were always well stocked.

Legionnaire testing had been completed in 2013 and the practice manager assured us this was due to take place again this year.

Clinicians were responsible for ensuring infection prevention and control standards were maintained between patient appointments. The practice had an up to date infection prevention and control policy in place. The Nurse practitioner, who was new to the role, had recently been appointed as lead for infection prevention and control. She told us she planned to implement an infection control audit as soon as possible and to review the existing policy.

Equipment

There was a contract in place to ensure that medical equipment was calibrated to ensure it was in working order. The practice also had contracts in place for portable appliance tests (PAT) to be completed on an annual basis.

The practice had a defibrillator which ensured they could respond appropriately if a patient experienced a cardiac arrest. Staff told us that they were trained to use this equipment. Emergency equipment including oxygen was readily available for use in the event of a medical emergency.

A blood pressure monitor was available in reception for patients use. Patients were encouraged to present the result of this to the reception team who forwarded the results to the nurse for analysis and follow up.

Staffing & Recruitment

The practice had a policy for the safe recruitment of staff which included guidelines regarding seeking references, proof of identity as well as obtaining criminal record checks for all staff. The policy made reference to the old system as opposed to the new DBS (Disclosure and Barring Service) checks. However when we checked a random sample of three staff files we found the relevant checks had been carried out.

There was an effective system to monitor staff training. Practice managers had an oversight of this but encouraged staff to take responsibility to highlight any areas where training was needed.

The practice employed 19 staff members excluding the GP partners and GP trainees at the practice.

Good

Are services safe?

We found that clinical staff registration with their respective professional bodies was checked on an ongoing basis. On the day of our inspection we did not find evidence that this was carried out for the GP Partners. The practice manager has assured us since the inspection that this has been addressed.

Monitoring Safety & Responding to Risk

The practice team had agreed the requirements for safe staffing levels at the practice. Staff worked regular sessions or agreed set hours and set days each week to consistently maintain the service provided. Practice management meetings were held to look at staffing levels and these were currently under review due to new staff being in post.

There was little staff turnover at the practice. We saw evidence the practice tried to plan ahead if a vacancy was anticipated to minimise any impact upon the service.

We were told that locum GPs were rarely used as the practice had sufficient staff to maintain a safe and efficient service. On the day of our inspection one GP was off sick. We saw another GP stepped into to cover patient appointments. Reception and administration staff, in the event of sickness or leave, supported each other by providing appropriate cover amongst the remainder of the staff.

GPs and Nurses took lead roles for example in palliative care, infection control and safeguarding adults and children. If any findings identified emerging risks these were shared with staff so action could be taken to improve service delivery.

An extended hour's service on Wednesday and Thursday until 7.45 pm was available to meet the needs of the working age population. Emergency appointments were also available each day.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan in place which was accessible on the practice computer system and given to staff on induction. This covered plans for a number of potentially disruptive events. Staff knew how to find this guidance and were knowledgeable about what to do in the event of an emergency.

All emergency equipment was regularly checked and readily available for staff to access in an emergency.

The lead receptionist maintained checks on the oxygen available in the reception area. Whilst the nurses checked emergency medicines, the health care assistant was responsible for the vaccine fridges.

Each consultation and treatment room had access to a panic alarm on the computer system which could be used to raise an alert to all other members of staff if assistance was required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided a service for all age groups. GPs had particular interest areas. For example one GP worked collaboratively with the local hospice and was the practice lead for palliative care.

We saw that the practice followed national strategies relating to caring and treating patients. For example people aged over 75 years of age had a named GP. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease and patients completed annual health reviews.

The GPs and nursing staff could clearly outline the rationale for their treatment approaches. They were familiar with current best practice, accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with clinical staff that staff completed assessments of patients needs in line with NICE guidelines and these were reviewed when appropriate.

Clinical staff told us how they accessed best practice guidelines to inform their practice and clinical staff met regularly to share such updates. The practice was a training practice, which, we were told, encouraged learning not only for trainee GPs but ongoing for senior doctors.

Management, monitoring and improving outcomes for people

The Practice has a system in place for completing clinical audit cycles. Examples of clinical audits included high risk Atrial Fibrillation patients who were prescribed anticoagulants. Atrial fibrillation is a heart condition which causes an irregular and often abnormally fast heart rate. Clear learning points were identified and implemented. We saw evidence that this audit had directly improved the outcomes for these patients.

The patients we spoke to who had long term health complaints confirmed they received regular health reviews and were called by the practice to arrange these. We saw evidence of these systems in the practice.

The flu vaccination program offered at the practice was well structured and resulted in a high uptake.

Effective staffing

The practice had policies and procedures in place to support staff in carrying out their work. For example, newly employed staff were supported and supervised in the first few weeks of working in the practice to help confirm they were able to effectively carry out their role. An induction programme included time to read the practice's policies and procedures. Staff, including trainee doctors, and locum GPs had easy access to a range of policies and procedures via the computers systems to support them in their work.

A training policy was in place and training included in-house training, external training courses and on-line training in the form of E-Learning. The mandatory training included annual fire safety, moving and handling and child and adult safeguarding.

GPs were up to date with their revalidation. The practice offered annual appraisals to review performance at work and identify development needs for the coming year. Records confirmed annual staff appraisals took place.

Staff told us they received appropriate and effective support. Nursing staff told us they worked well as a team and had good access to support from each other and their GP colleagues.

There was a range of staff meetings. These meetings provided communication, support and learning opportunities.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. Information received from other agencies, for example, accident and emergency was read and actioned by the GP and scanned onto patients' records in a timely manner.

The practice staff worked with the local community nursing team, midwives, and health visitors. We found that the clinicians appropriately referred patients to community teams, for example pregnant women were seen for their ante-natal appointments by the community midwives.

The local hospital trust provided a midwife to attend the practice four days a week. We spoke to the community midwife who spoke highly about the service provided at Owen Road. They explained that they and other visiting professionals such as the health visitor and district nurse

Good

Are services effective?

(for example, treatment is effective)

were invited to relevant staff meetings where their input was encouraged. The midwife told us the communication from the practice was excellent and they found the staff team to be professional and approachable.

Patients we spoke with who had been referred to other services told us that the practice liaised well to keep them informed about their treatment

Nursing home patients represented 0.18% of the patient population on the practice patient list. The practice manager explained they had arranged a meeting with the local care home to improve the relationship with the practice.

Information Sharing

All staff completed the practices' mandatory training which included; Information Governance and Equality and Diversity training

Information sharing took place appropriately, such as within multi-disciplinary team meetings, safeguarding adults and children, palliative care meetings and shared care such as hospital referrals and discharges and community team involvements.

Consent to care and treatment

Staff informed us they had access to interpreter translation services for patients who required this support. A portable hearing loop was also available for staff to assist patients with hearing difficulties.

Nursing staff were aware of how to locate the practice consent policy which highlighted the Mental Capacity Act (MCA) and best interest decisions but staff had received no formal training. This legislation is a legal requirement that need to be followed to ensure patients who are unable to give consent for certain aspects of their care and welfare receive the right type of support to make a decision in their best interest. We have since received information that practice staff have been offered training in this area from the CCG.

Capacity and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. We found that clinical staff understood how to ascertain and consider whether 'best interest' decisions for patients who lacked capacity were required and the nurse or GPs sought approval for treatments such as vaccinations from the child's legal guardian.

Health Promotion & Prevention

The practice supported patients to manage their health and wellbeing. The practice offered vaccination programs, long term condition reviews and provided health promotion information to patients. A variety of health promotion leaflets were available in the waiting area, including details of smoking cessation. Information was available to allow patients to make informed choices.

The practice also provided patients with information about other health and social care services such as carers support and advocacy services.

At the time of inspection the practice was promoting flu vaccinations. We saw a variety of promotional literature and the times for these clinics.

The practice had recently participated in a national initiative seeking to develop caring communities. Representatives of Help Direct had held a weekly clinic at the practice. Help Direct is a support and information service for adults that seeks to assist people with a wide range of issues. The uptake of this weekly clinic had been poor, therefore the practice had arranged for Help Direct to attend the weekend flu clinics where the uptake was much better. Staff were also aware of how to refer people to this service. We were told that this service might include assisting people with learning difficulties, mental health problems and those who had experienced bereavement.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The staff we spoke with told us they took pride in providing good patient care. On the day of our inspection we saw patients were spoken to in a friendly manner and with respect.

The patients we spoke to commented on the friendliness of the staff team.

We considered the confidentiality in the reception and adjoining patient waiting area. The reception desks in both buildings were situated to the side of the waiting area, where soft music provided a distraction to the conversations taking place at the desk. A notice was displayed which advised patients that a separate room was available should they not wish to discuss matters at the reception desk. Consultation rooms had lockable doors and privacy curtains. We saw that doors were closed during patients' appointments.

The computer system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, learning disability or recent bereavement.

Patients spoke positively of their dealings with both clinical and non-clinical staff. We observed staff speaking with patients and heard them engaged in conversation with patients on the telephone. Patients we spoke with described staff as helpful and friendly. They confirmed they were treated kindly and with dignity and respect. We observed that staff were warm, polite and respectful in dealing with patients.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in the decisions made about their care. They told us they felt the GP would listen if they had any issues or concerns and that their consultations were never rushed. We were told that if patients wished for a friend or family member to attend for support, that this was not a problem.

Care Plans were in place for vulnerable patients. These were individualised created in consultation between the GP and patient. These patients were also given a direct access telephone number for the practice

Patients confirmed that they felt involved in decisions about their care and treatment. They told us diagnosis and treatment options were clearly explained.

Patient/carer support to cope emotionally with care and treatment

One of the partners had a special interest in end of life care and also worked collaboratively at a local hospice. The practice demonstrated a caring and sensitivity attitude towards bereavement and strived to achieve dignified death for patients. Care plans were in place for those people approaching the end of their life. These were in place with the input of the patient and other agencies supporting the patient.

Multi-disciplinary palliative care meetings were held on a monthly basis to discuss the needs of those approaching end of life. The practice also held regular meetings in-house to look at patients who had recently died and to offer support to their carers or relatives. We were told this included a home visit to offer support. A notice board was also available to staff which provided a visual prompt of those patients who had recently passed away. The staff we spoke to knew patients well and we observed this in interactions and this was confirmed by patients.

One patient we spoke with who had lost a loved one praised the practice highly for their care and support during this difficult time.

The practice held a register of carers. In the reception area we saw a display of information for carers which provided signposting to support on a wide variety of issues

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The patients we spoke with were happy with the care and treatment they received from the practice. Patients commented positively on the consultation, referrals and treatment provided.

We were told by clinical staff how the practice worked with patients to ensure they received the treatment they required. This included follow up phone calls to women who had not attended for screening appointments after reminder letters had been sent.

At the time of inspection the practice was actively promoting flu immunisation. There were posters and banners around the waiting area to draw this to the attention of patients.

The practice had an active patient participation group which was held virtually to encourage participation. We spoke to one member of the group who told us they were encouraged to raise issues and concerns and that these were taken seriously by the practice manager who always fed back on what actions were taken to address any problems.

We received 13 completed Care Quality Commission comment cards and spoke with six patients. All were very complimentary about the care provided by the clinical staff and noted the overall friendliness and behaviour of all staff. They all found the GPs and nurses to be competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

Tackling inequity and promoting equality

The new patient list was open and staff were able to offer appointments to patients, including those patients with no fixed abode. Staff had received training in equality and diversity.

Public Health England's data found that the practices average male life expectancy of 75.61 and female life expectancy of 81.1, compared to England's national average is 78.9 for males and 82.9 for females.

Clinical staff held a number of regular clinics at the practice to review for example chronic disease management, immunisation and vaccination, and diabetes.

Access to the service

Patients with a physical disability were identified on the practice computer system and suitable ground floor arrangements were made for consultations. A disabled toilet and baby changing facility was available. The reception area was fitted with a hearing induction loop. The practice itself was set back off the main road on an incline. Steps or a ramp led into the practice. One person commented that the incline was sometimes difficult for them when they felt unwell. Staff told us they offered home appointments if a person could not get into the practice or would offer assistance on the day.

Same day appointments were available and we were told that these had been increased to encourage people who may be more likely to forget about future appointments or be less likely to book.

We saw practice action plans based on patient feedback to address concerns about getting through on the telephone lines in the morning. Extra telephone lines were available at busy times and the online appointments system was advertised through the practice. The practice was also looking to introduce a new telephone line system.

Home visits and urgent on the day appointments were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and on the practice website.

The practice monitored their appointment system on an ongoing basis. Meetings took place on a quarterly basis to discuss patient need in this area.

Listening and learning from concerns & complaints

The practice has a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

The practice handles complaints according to their policy as they were received. The practice also held an annual audit of all complaints. 17 Complaints had been made in 2013. We saw these had been handled and responded to appropriately or where failings in the process had been identified this was acknowledged and action taken. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

subject of the complaint was analysed for trends in order to assess if there was a common problem. This enabled the practice to learn from incidents and implement changes to improve the service provision

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and overall strategy for the practice and its development. We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

GPs attended prescribing, palliative/supportive care meetings, safeguarding meetings and shared information within the practice.

Staff told us the various meetings helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

We saw evidence that the future of the practice was planned and the management was responsive to the changing needs of its patients. A nurse practitioner and a salaried GP had recently been appointed.

Governance Arrangements

The staff we spoke with were clear on their role and responsibilities within the practice.

We found some policies required updating, including whistleblowing and recruitment. Although these had been recently reviewed the system in place to check their relevance was not always effective.

GP's had lead roles and took responsibility for a number of clinical areas. GPs were involved in training and supporting trainee GP's. Individual aspects of governance such as complaints, risk management and audits within the practice were allocated to appropriate staff, for example the practice manager held responsibility for the oversight of complaints. The practice submitted governance and performance data to the CCG.

Leadership, openness and transparency

The practice had systems to identify, assess and manage risks related to the service.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to practice procedures and staff training.

The practice carried out audits and checks to monitor the quality of services provided.

A 'team talk' leaflet was produced for staff every month as an additional method of sharing information directly relevant to the staff team.

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

We saw from minutes of meetings that appropriate staff members attended and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered.

The 13 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained.

The practice had an active patient participation group. We spoke to one member who spoke highly of the service and their ability to listen to concerns and suggestions and act appropriately. We were told that such meetings had taken place remotely to encourage participation.

Management lead through learning & improvement

Staff told us about how the practice learned from significant events and the improvements and reviews following any change implementation that took place.

The practice partners and managers were supportive of staff's personal development and provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the service provided to their patients. We spoke to two staff members who had progressed their careers whilst working in the practice. Both felt supported in their roles and confirmed they had access to training to do their roles effectively.