Flixton Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Flixton Road Medical Centre on 7 January 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, caring, responsive and well-led services. It was also good for providing services to all the population groups. The practice required improvements in the way they provided effective services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

Importantly the provider should

- Ensure reception staff are aware of the Gillick competencies and the right for young people to attend the practice without a parent.
- Ensure there are processes in place to collect the views of patients.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. People's needs were assessed and care was planned and delivered in line with current legislation. The GPs were aware of assessing patients' capacity and staff promoted good health. Staff had received training appropriate to their roles. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with their preferred GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was communicated to staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice was in the process of setting up a patient participation group (PPG). Staff had received inductions and had regular performance reviews.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. There were processes in place so patients could have an annual structured review to check that their health and medication needs were being met. GPs worked with other services to deliver a multidisciplinary package of care when appropriate.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Staff had received safeguarding training. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with other services. Reception staff were, on occasions, unhelpful to young people wishing to access the service without a parent accompanying them.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place care planning for patients including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary. Patients could be referred for counselling.

Summary of findings

What people who use the service say

We received 29 completed CQC patient comment cards and spoke with three patients during our inspection.

Patients we spoke with and who completed CQC comments cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their privacy and dignity was maintained. Patients told us they received excellent care in a friendly manner. They said they felt GPs listened to their concerns and appointments were easy to access. Patients told us they had confidence in the GPs and nurses.

We also looked at the results of the most recent national GP patient survey. This told us:

- 90% of respondents said the GP was good at explaining tests and treatments to them (CCG average 84%).
- 97% of respondents said the nurse was good at explaining tests and treatments to them (CCG average 75%).
- 95% of respondents said the GP was good at involving them in decisions about their care (CCG average 86%).

Areas for improvement

Action the service SHOULD take to improve

- Ensure reception staff are aware of the Gillick competencies and the right for young people to attend the practice without a parent.
- Ensure there are processes in place to collect the views of patients.

Flixton Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor and a practice nurse specialist advisor.

Background to Flixton Road Medical Centre

Flixton Road Medical Centre is a two story converted house on a main road in Flixton. The practice formed in 2012 when two single handed GPs merged.

There are three GPs working at the practice, two male and one female. There also two practice nurses, a practice manager and administrative and reception staff.

The practice is open Monday to Friday 8am until 6pm, except on a Wednesday, when the practice closes at 1pm.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 5582 patients were registered with the practice.

Flixton Road Medical Centre had opted out of providing out-of-hours services to their patients. This service was provided by a registered out of hours provider.

Why we carried out this inspection

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

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. These groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- 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 7 January 2015. During our visit we spoke with a range of staff including two GPs, the practice nurse, the practice manager and reception staff. We spoke with three patients who used the service. We observed how people were being

Detailed findings

cared for and talked with carers and/or family. We reviewed 29 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents, including mistakes were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Bolton Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

The staff we spoke with were aware of how to report significant events. We saw that staff had received training in how to recognise and report a significant event, and we saw examples of this being done by nurses. We saw that significant events were openly discussed at monthly clinical meetings. The GPs told us they were also discussed during their informal meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred. We saw examples of national patient safety alerts and significant events being discussed with staff at practice meetings. There was evidence that the practice had learned from these. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw the documentation kept relating to significant event audits. Details of what occurred, what went well, what could have been done and what changes were agreed were recorded. In addition, there was a final part of the significant form that was completed during the appraisals of staff involved in the significant event. This was to prompt discussions about how the outcome of significant events improved patient care.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. A flowchart for reporting concerns was displayed in clinical rooms and relevant contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All the GPs had been trained to the appropriate level (level 3), the nurses to level 2 and non-clinical stall to level 1. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. We saw evidence of appropriate referrals being made to the local authority.

There was a chaperone policy in place. This stated staff should have received on-line training prior to carrying out chaperone duties. It also stated staff should stand inside the curtain while chaperoning during an intimate examination. We saw evidence in meeting minutes that chaperoning was discussed at a practice meeting in November 2014. The staff we spoke with who had acted as a chaperone were aware of their responsibilities. The policy stated that the chaperone should annotate the patient's notes following the examination taking place. GPs were annotating the notes but they told us that following the inspection this process would be changed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The action to take in the event of a potential failure was described and we saw staff followed the policy. The practice nurses were responsible for checking the fridge temperatures.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked, including those in the GPs' bags, were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that the practice worked closely with the CCG medicines management team who visited regularly. A number of audits had been carried out around guidance from the National Institute of Health and Care Excellence (NICE) on the use of certain medicines. This provided evidence of the safe use of medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice started electronic prescribing approximately two years ago. The pharmacies in the area were now set up for electronic prescribing and they found this cut down on possible errors. GPs carried out electronic prescribing following home visits and this reduced errors that could be made by pharmacists due to misreading the handwritten prescriptions.

We saw evidence that medicines and prescribing were discussed at the regular practice meetings. Updates were disseminated to all relevant staff. We saw the practice was due to start face to face reviews of all patients who required 10 or more medicines to make sure they were prescribed the most appropriate medicines for their conditions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaners attended the practice each evening for approximately two hours. We saw there were cleaning schedules in place and cleaning records were kept to show the schedules had been completed. We saw there were spillage kits available for use if needed during the day. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. Training for staff had been provided by the infection control lead at the CCG.

We saw evidence that infection control audits were carried out. The most recent full audit had been carried out by a modern infection control matron in June 2014. Areas for improvements had been identified and we saw an action plan had been put in place that was monitored by the practice manager. The majority of improvements required had been carried out.

Infection control was an agenda item at practice meetings. We reviewed meeting minutes and saw evidence that information including areas requiring refurbishments were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Disposable privacy curtains were around couches in consultation rooms and these had been changed 5 December 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. We saw evidence of calibration of relevant equipment in February 2014. The testing of portable electrical appliances and fire equipment had also been carried out at this time.

Staffing and recruitment

We saw the practice's recruitment policy that had been reviewed in November 2014. This set out the standards it followed when recruiting clinical and non-clinical staff. The policy stated that references would be sought from the last two employers if possible but other references would be considered. The practice manager explained that they sometimes found it difficult obtaining two references from previous employers, as some staff had not worked recently. To ensure employees were of good character they had decided to ask for a Disclosure and Barring Service (DBS) check for all staff.

Good

Are services safe?

The records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example a full employment history with any gaps explained, proof of identification, references where possible, qualifications, DBS checks and registration with the appropriate professional body were all checked.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. This had recently been amended due to the needs of the practice. We saw the practice manager checked weekly to see if enough GP appointments were being offered. They also checked throughout each day to identify if further appointments needed to be put in place. We saw the practice carried out audits on the number of people attending the out of hours service to see if they were attending because they were unable to get an appointment at the practice during the day. To date they had found further appointments were not required.

If a locum GP was required a regular one was used from an agency and we saw all appropriate checks were completed on locum GPs prior to them working at the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included an annual full risk assessment of the building to check for example manual handling, slip and trip risk and fire risk. The practice used a local builder to carry out any small repairs to the building, and the practice manager said they attended promptly when called. Discussions with staff showed the team were proactive in recognising risk and reported any issues to the practice manager so they could be resolved.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support during October 2014. Oxygen was available for use in an emergency and we saw this was checked weekly to ensure it was ready for use. The practice had decided an automatic external defibrillator (AED) would be beneficial in case a patient suffered a sudden cardiac arrest. We saw evidence that and AED had been ordered.

Emergency medicines were available and we saw these were checked every month to ensure all those required were available and within their expiry date. The medicines we checked were all in order, and all staff knew where to locate emergency medicines and equipment. Computers had a panic button on them, to alert staff in case of an emergency. We saw evidence that training on its use was carried out in December 2014.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was very detailed and all staff had access to a copy.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies which were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by the GP. We saw examples of GPs following NICE guidance and arranging for urgent tests to be carried out for patients presenting with some conditions. They then disseminated the information to other staff within the practice. Staff confirmed they received regular updates at their practice meetings.

All new patients were required to attend an appointment with the practice nurse as part of their registration process. This was a 20 minute appointment where a general health check was carried out and lifestyle questions discussed. Following the appointment the nurse allocated the new patient a GP.

If patients did not attend their review the nurse telephoned them to try to make a convenient appointment. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

Discussion with GPs and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff conducted consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. There were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw evidence of the clinical audits cycles that had been carried out. These included an audit on the prevalence of chronic kidney disease (CKD) compared to national prevalence. An audit on the secondary prevention of osteoporotic fragility fractures in post-menopausal women had been carried out over a period of 12 months. An audit cycle on the prevalence of epilepsy had been started but had not been completed at the time of our inspection. The completed audit cycles showed there had been a positive outcome for patients.

We saw evidence that all referrals except neurology were peer reviewed within the clinical commissioning group (CCG). Feedback was provided to GPs about whether or not the referral was considered appropriate.

Significant event audits (SEAs) were used to review when patient care had not gone according to plan. We saw that SEAs were discussed at meetings within the practice with outcomes used to influence learning within the practice.

When a patient attended the accident and emergency (A&E) department, walk in centre or out of hours service information was received electronically at the practice. This information was reviewed by GPs to consider if any follow up action was required. In these circumstances the patient would be contacted and an appointment arranged.

The practice nurses usually managed patients with chronic conditions. Although GPs had an interest in these the practice nurses carried out annual reviews for patients and monitored their conditions. The practice had recently carried out an exercise to recognise and correctly read code conditions. The practice had seen there was a higher prevalence than expected for some illnesses, and this was due to correct identification and read coding.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The majority of staff had worked at the practice for several years. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

We saw that the practice manager monitored training to ensure all staff had completed what was required. They kept a training plan and we saw they were aware of the training needs and goals for each staff member.

All staff, including the practice nurse and practice manager, undertook annual appraisals that identified learning needs. Personal development plans were put in place for each staff member and these were monitored throughout the year to ensure any learning or development requirements were met. The practice manager monitored the continual professional development (CPD) of the practice nurses. Staff told us they felt supported at work and were able to request additional training if they thought it would be beneficial. They told us the GPs and practice manager had an open door policy and they felt able to approach them for advice.

We saw that all new staff followed a formal induction programme. The practice manager monitored this and a checklist was in place to show when new staff had completed each part of their induction training. Training was completed one step at a time and the induction period could be extended if it was felt it was required. Administrative staff carried out different duties on a rota basis so they had experience in different aspects of their role and could cover all areas in times of staff shortages.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. The GPs told us they reviewed the information, took any appropriate action and ensured their patient records were up to date.

The practice nurses attended a practice nurse forum within the CCG. This provided them with opportunities to share learning that had been gained from significant event audits and other areas. The forums were an opportunity for networking with the wider team. The practice nurse told us the district nurses did not attend and they had little contact with them. They did have regular contact with midwives, although they weren't based at the practice.

We saw the practice was in discussion with the CCG about the possibility of working with other practices in a formalised way.. This would enable practices to work with other practices to provide extended opening hours and weekend appointments. We saw discussions were taking place with other practices about providing GP cover for nursing homes.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and

Good

Are services effective?

(for example, treatment is effective)

treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

The latest GP patient survey reflected that 90% of respondents said the GP was good at explaining tests or treatments to them (CCG average 84%), and 97% said the same of the practice nurse (CCG average 75%). Also 95% of respondents said the GP was good at involving them in decisions about their care (CCG average 86%), with 95% saying the same of the practice nurse (CCG average 66%).

We saw that the practice had consent forms for minor operations. The clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify young people aged under 16 who have the legal capacity to consent to medical examination and treatment. However, we found at times reception staff were to young people requiring an appointment. At times they asked where their parents were. We saw that by booking an on-line appointment and checking in for their appointment electronically patients did not need to interact with reception staff.

GPs told us how they would obtain consent for patients who had, for example, a learning disability.

Health promotion and prevention

We saw that new patients registering with the practice were required to have a new patient appointment with the practice nurse as part of the registration process. During the appointment information such as the patient's height, weight, smoking and alcohol consumption status and family history usually were discussed and relevant information recorded. Advice about lifestyle was given and if required an appointment with the practice nurse or GP was arranged.

Flu vaccinations were offered to appropriate patients, including young children. The practice had monitored the take-up rate for adult flu vaccinations. We saw meeting minutes that this had been discussed, and as a result the GPs took flu vaccines on home visits so they could carry out the procedure on an opportunistic basis if required. There had also been a low-take up rate for the childhood flu vaccination, and all parents had been written to explaining the importance of the vaccination and asking them to make an appointment. If patients failed to attend a pre-booked appointment the practice contacted them by telephone.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The patient survey showed that 87% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 85%) and 95% thought their GP was good at listening to them (CCG average 89%). The figures when asked the same about the nurse were 99% (CCG average 79%) and 97% (CCG average 80%). The survey showed that 82% of patients found the receptionists helpful (CCG average 89%), 92% thought the GP gave them enough time (CCG average 87%), and 98% thought the same of the nurse (CCG average 81%).

The patients we spoke with all gave us positive comments about all the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. Patients told us they were given enough time during their appointments and the GPs and nurses listened to them. All the CQC comments cards received gave very positive comments about the staff. They commented that staff were always thoughtful, caring and polite.

Patients told us they were able to request a GP of a particular gender. GPs told us that although the two permanent GPs were male there was a female student GP at the practice. They also said that nurses were able to carry out several procedures if a patient wished to see a female clinician.

Patients told us there were no problems with privacy in the reception area. There was a private room available if a patient requested a confidential conversation with staff. The patients we spoke with told us they had used the practice for several years and thought they were treated with respect and in a dignified way.

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

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed patients responded particularly positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 82% of practice respondents said the GP involved them in care decisions (CCG average 77%) and 90% felt the GP was good at explaining treatment and results (CCG average 84%).

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. When an interpreter was required this was highlighted on the patient's records. We saw notices in the reception areas informing patents this service was available. In addition to this one of the GPs spoke several languages including Urdu and Punjabi.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection gave us positive feedback about emotional support offered by the practice. We were told that counselling, including bereavement counselling, could be arranged by the GPs. A patient who had attended counselling told us it had been very beneficial. The CQC comments cards we received also provided evidence of the practice providing emotional support. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website also told people how to access a number of support groups and organisations. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

All patients over the age of 75 had been informed by letter who their named GP was. Although one GP had a specific interest in chronic obstructive pulmonary disease (COPD) GPs did not take the lead for specific conditions. The practice nurse managed most long term conditions. Patients were asked to attend an appointment for a review of their condition during a specific month. They had found that by arranging the review appointment by telephone fewer patients failed to attend. The practice nurse told us that if a patient did not make or attend an appointment for a cervical smear test they telephoned them to try to arrange one. They also carried out cervical smears opportunistically if a patient had attended the practice for another matter.

The practice kept a register of patients with a learning disability. The practice nurse carried out annual reviews for these patients.

Where a patient had a higher risk of unplanned hospital admittance they had a care plan in place. These care plans were monitored and updated regularly so that any increased risk could be identified and appropriate action taken. The GP told us it was too early to be informed if hospital admissions had decreased.

The GPs explained they regularly looked at ways to reduce the number of visits required to the practice to bring positive benefits to the patients. They started electronic prescribing approximately two years ago and found it is preferable to patients.

The practice was in discussion with other local practices about pooling the reception staff. They thought this would help as receptionists in the group, especially for smaller practices, could have responsibility for different aspect of administration work.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They told us there were very few patients who did not speak English as a first language but translation services were available. The practice had identified certain groups of patients, such as those with a learning disability or with caring responsibilities, and additional help was provided in an appropriate manner. Patients who were housebound had home visits when they required an appointment.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

The premises and services met the needs of people with disabilities. The practice was fully accessible for patients using a wheelchair, or with a pushchair, and although some consultation rooms were on the first floor, appropriate ground floor rooms were always used when required. There was an accessible toilet.

Access to the service

The practice was open Monday to Friday from 8am until 6pm, except on a Wednesday when it closed at 1pm. When the practice was closed calls were directed to a registered out of hours provider. The practice had assessed the impact of being closed on a Wednesday and found there was not an increase in patients accessing the out of hours service of walk in centre. They were in discussion with the clinical commissioning group (CCG) about the possibility of starting to offer extended hours appointments.

We spoke with three patients during our inspection. Two of these had requested an urgent appointment and had been given one for within two hours of their telephone call. The other had booked a routine appointment a week earlier. They told us routine and emergency appointments were usually available when needed. The CQC comments cards we reviewed confirmed this. Patients commented that appointments were easy to access, and a GP would telephone them to assess their need if emergency appointments were booked up.

The results of the latest national GP patient survey showed that 76%% of respondents found the experience of making an appointment as good. This was slightly below the CCG average for the area of 78%. More positive results were that

Good

Are services responsive to people's needs?

(for example, to feedback?)

69% of respondents said they could usually access an appointment with their preferred GP (CCG average 60%), and 91% of respondents said they found it easy to get through the practice by telephone (CCG average 81%).

The practice manager explained the appointments system to us. Routine appointments could be booked eight to 10 weeks in advance. Emergency appointment could be requested from 8am each day. They told us it was very unusual for a patient not to be seen within 48 hours of requesting an emergency appointment. GPs regularly checked demand throughout the day and were flexible in the way they worked. They telephoned patients if they requested an appointment when all the emergency appointments were booked up. They were able to add additional appointments on to their surgeries and always did this if they assessed a patient needed to be seen. Children were always seen. We checked the availability of appointments at 11am on the day of our inspection. The first available emergency appointment was at 11.40am that day, and the first available routine appointment was in two working days.

Telephone appointments could be made by patients. GPs also carried out home visits to housebound patients. In addition, they had approximately eight residential or nursing homes that they regularly visited. On the day after a bank holiday the practice operated an open surgery. No routine appointments were bookable for these days so that all patients who needed to be seen were able to access a GP.

When the practice was closed, including Wednesday afternoons, calls were redirected to a registered out of hours provider.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy had been reviewed in October 2014. This gave full instruction about the process to follow if a complaint was made. The practice manager was responsible for managing complaints and the process was overseen by a GP. The staff we spoke with were aware of the complaints process and referred patients to the practice manager when appropriate. We saw that complaints and the action following complaints were discussed during practice meetings.

We looked at the complaints that had been made in the 12 months prior to our inspection. A register of complaints was kept that was easy to understand and easy to identify any patterns. We saw that verbal complaints were also included in the complaints register. We saw an example of a verbal complaint, where changes to practice had helped to prevent the incident reoccurring. In this case the person making the complaint had written to the practice manager to say thank you for the way the complaint was handled.

We saw that all complaints were investigated and the practice manager recorded what had been done well, what could have been done better, and what changes to practice, if any, had been agreed. How the learning was implemented was also recorded.

Information about how to make a complaint was available in writing at the practice and on the practice's website. The patients we spoke with told us they were aware of how to make a complaint and would not feel uncomfortable doing so if required.

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

There was a well-established leadership structure with clear allocation of responsibilities amongst the GPs and the practice team. The two partners told us they regularly discussed succession planning for themselves and other staff. They communicated with their staff so they were aware of their future plans.

GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs were committed to providing a high quality service to patients in a fair and open manner. The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. Clinical staff met formally every month. The minutes provided evidence that performance, quality and risks had been discussed and any required actions were monitored. Clinical staff also had informal get-togethers at least weekly and GPs told us if there were any issues to discuss they did not wait until the next scheduled meeting. They said they were looking at ways of using technology such as smartphones to record these informal meetings as they had identified they needed to record what had been discussed.

The practice manager told us it had been difficult to arrange meetings for reception staff. They had recently decided that meetings would be held every three months on a Wednesday afternoon when the practice was closed. The first meeting had been held in November 2014 and the next was scheduled for February 2015. Reception staff told us they found the last meeting useful and they thought these formal meetings would be beneficial. The practice manager communicated formally with staff every week by circulating a weekly summary by email. This contained information such as what on-line training needed to be updated and reminders of changes to practice.

As part of their forward planning the GPs were looking at the skill sets of their staff. They explained that as it was a small practice it was difficult for enough staff to be competent in aspects of work such as scanning documents and read coding. The practice manager had devised an induction programme that gradually built up the skills of new staff. GPs were talking with other practices in the area about the possibility of pooling reception staff to make tasks like this more efficient.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at clinical meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw completed clinical audits showing a positive impact on patient outcomes.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk, patients and staff were being kept safe from harm.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us the GPs and the practice manager had an open door policy and were very approachable.

We saw that clinical staff meetings were held every month and meetings for other staff had started to be held every three months. GPs also met informally at least every week and they were looking at ways of capturing what was discussed during these get-togethers. They had recognised that as issues such as significant event audits and specific patient care were discussed they needed a record and were thinking of using smartphone technology for this. A weekly summary was produced for staff and circulated by email so they were updated about relevant aspects of the practice.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice did not have a patient participation group (PPG). They had formed in 2012 when two practices had merged. The practice manager told us they were in the process of arranging a PPG and hoped to have one in place during the first half of 2015. They were making arrangements to print information on the bottom of prescriptions and on the website so patients knew what a PPG was and how they could join.

The practice had started to use the friends and family test in December 2014. They had received 40 responses during December 2014 and most responses had been extremely positive.

The practice did communicate with their patients and carried out surveys but these were usually for specific issues and not for general satisfaction. We saw the latest survey had been to ask about patients' use of the walk in centre and their knowledge of what the practice could do for them. This had enabled the practice to find out why they had used the walk in centre instead of the practice and make sure the practice met the needs of their patients. Changes made following the survey included the promotion of on-line services that patients were unaware of and making sure that patients knew they could book routine appointments eight to ten weeks in advance.

Management lead through learning and improvement

Staff told us they felt they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. A record was kept of the training courses they had attended or training they had accessed on-line. Mandatory training was up to date. Staff told us they were supported in their personal development.

We saw evidence that the continuing professional development (CPD) of the practice nurse was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

The GPs were up to date with their appraisals and one had completed their revalidation. Appraisals for all staff were carried out annually and were up to date. The GPs carried out the appraisals for nurses and the practice manager and the practice manager appraised other staff.

The practice was a training practice and it actively took part in research. There was evidence that during the merger of the two practices in 2012 patients' needs were at the centre of their plans. The practice was forward thinking and looking at changing the clinical system to support the CCG agenda and improve practice functionality.