

Boughton Medical Group

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Boughton Medical Centre is based close to the centre of Chester and is registered with the Care Quality Commission to provide the regulated activities:

- Diagnostic and screening procedures
- Maternity and midwifery services; and
- Treatment of disease, disorder or injury.

The practice opened from 8.00am to 6.30pm, Monday to Friday and had a patient register of almost 12,000 people. Before our inspection we left comment cards for patients to complete and drop into a box for our review. We found a number of cards were completed and all but one response was positive. A negative comment was made regarding difficulties in securing an appointment with a GP.

We spoke with six patients attending the practice on the day of our inspection, who shared their views on how the practice people's healthcare needs. They told us they found nursing staff and GP's caring and compassionate. We talked with five people from the Patient Participant Group. The members of the group told us they thought the practice was very well-led and that all staff were knowledgeable, caring towards patients and that they were always treated with dignity and respect.

We found patients of working age had appreciated the Saturday flu clinics that had been run in the past year. At that time they could visit the surgery on a none working day to take up the offer of this vaccine.

The practice met the requirements of the Equality Act. Access to the building was wheelchair user friendly and all internal doorways were sufficiently wide enough for wheelchairs to pass through. A hearing loop system for people with impaired hearing or deafness was available and a member of staff was trained in the use of British Sign Language, for people who used this form of communication.

The surgery had five nurse practitioners who specialised in particular areas of health care and condition management. Older patients visiting the practice on the day of our inspection told us they valued the blood taking clinic which was held at the practice.

A variety of clinics were run for pregnant women, new born babies and parents of very young children. All immunisations for babies and young children were delivered from the practice.

The practice operated safely and had robust systems in place to ensure patient treatment followed best practice guidelines. Governance processes were in place that enabled the practice to comply with regulations and to deliver safe health care.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The clinical care of patients was safe. The surgery and all equipment was well maintained. There were systems in place to protect patients' safety, for example in infection control and review of medicines used. Clinical reviews were in place to help ensure that patients experienced the best possible outcome from their treatments. The practice showed us how it recorded and analysed any serious incidents, and how lessons were learned from them. The sharing of information that came from these reviews was clear when talking to staff and looking at agendas and minutes of staff meetings. There were processes in place to ensure that all GPs and other clinicians maintained their professional development. Support staff had the skills and knowledge required to enable them to carry out their duties correctly.

Are services effective?

The practice was effective in meeting the demands of a growing patient register. The patient register numbered almost 12,000 people and to accommodate patients' needs, the practice offered 'express clinics' each day. At these clinics people could be seen by a nurse practitioner who could help with a wide range of common illnesses such as ear and throat infections, chest infections and urine infections and prescribe medicines for these conditions. In the event that a patient needed further advice or consultation with a GP, the nurse prescriber could allocate an emergency appointment for the patient on that day. Patients we spoke with recognised the value of these clinics, particularly those who worked full time and needed to be seen quickly by a health professional. The practice worked hard to meet the needs of patients across all population groups. We particularly found that older patients were well supported by GPs and the practice nurses.

Are services caring?

Patients told us the care they received was very compassionate and that they were always treated with dignity and respect. We saw an example of how the needs of patients' with learning disabilities were met and how continuity of care was protected by GPs and other staff at the practice in cases where this was key to a patient's successful treatment.

Are services responsive to people's needs?

The practice had conducted some analysis on registration of new patients at the surgery. Results showed that the practice experienced a rise in the number of patients from other countries,

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many of whom needed interpreter services. The analysis showed that appointment times for patients in this group were longer, typically 20 minutes per patient as opposed to the allotted 10 minute appointment time, and that the number of consultations per year was double that of other patient groups. By conducting this research the practice was able to act in a responsive way to meet the needs of this patient group, for example by printing information in a range of other languages, increasing the level and range of interpreter services, scheduling slightly longer appointment times and ensuring staff were aware of the cultural needs of this patient group.

Are services well-led?

The practice was well-led, in clinical as well as administrative support services. Leaders were visible, approachable and accessible. There was an open, transparent culture of learning which led to improvement in patients' experiences of care. Innovation was encouraged and this had delivered real improvements in patients' care and welfare, such as dementia care in the community and the accessibility of services to patients with a learning disability. Any decisions were made inclusively and took account of the opinions of patients and people who worked at the practice.

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

The practice was caring and responsive to the needs of older patients'. It had invested in advanced training for clinical staff that supported patients with dementia. After they were diagnosed, patients were supported and their progress followed for 12 months, something which had previously been identified as lacking.

There was also significant support for older patients' who still lived at home with the help of carers.

People with long-term conditions

The practice ran specialist clinics for patients with long-term conditions. Patients were seen by nurse prescribers who were specially trained to deliver treatment for chronic conditions such as diabetes and asthma, in line with recognised best practice.

Data we reviewed before our inspection showed that hospital admissions from patients within this group were low. This suggested that the management of long-term conditions was effective.

The practice had its own blood collection clinic. Patients told us this was something they particularly valued. Although the decision to run the blood collection clinic was not based solely on the feedback of patients, we did see evidence that the practice had been responsive to patients' personal circumstances and access to such services had been considered.

Mothers, babies, children and young people

We saw a variety of health-care initiatives targeted at this population group. The practice ran ante-natal and post-natal care clinics, mums' and babies' clinics and publicised any 'catch-up' immunisation campaigns, for example measles, mumps and rubella (MMR) vaccination programmes.

Confidential contraception advice for young patients was available and this was advertised through social media, the practice website and through posters displayed in the surgery. The practice was able to demonstrate commitment to confidentiality of young patients' health matters and effective use of social media to reach patients in these age groups.

We found there was limited representation of patients from this population group on the practice Patient Participant Group (PPG). The group explained that recruitment of patients to represent these age groups was difficult. We discussed ways of reaching these

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patient groups and perhaps ‘taking the group to them’, rather than people having to make a commitment to attend a physical meeting. The group said they could explore options to help achieve this, for example using Skype or video conferencing facilities

The working-age population and those recently retired

Patients we spoke with from this group said that overall they were happy with the service they received. Some patients we spoke with on the day told us that getting an appointment outside of working hours was always difficult and they wished that these appointments could be ‘protected’. We asked patients if they were aware of the Patient Participant Group (PPG). There was limited awareness of this among patients of working age. This meant the practice may not be hearing some of the problems experienced by this age group. This supported the data we reviewed before our inspection where the score for ‘convenient opening times’ was lower than expected for a surgery of this size. At the time of our inspection no one at the practice had lead responsibility for investigating and addressing this issue, or looking at how other practices managed this very common problem.

Patients we spoke with were aware of the blood collections clinic at the practice and valued this service. One patient told us they particularly valued the Saturday morning flu clinics that the practice runs each year. Patients said they were confident in the clinicians they saw and felt the treatments they were given were safe and effective.

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

We saw good examples of care delivered to patients who were, or could become, very vulnerable because of their health condition. Parents and carers told us about the care delivered by a GP at the practice, to patients who had a learning disability. They felt that the care and treatment delivered to these patients had been caring, effective, and responsive to their needs

People experiencing poor mental health

A lead nurse practitioner at the surgery maintained a register of patients who experienced mental health problems. The register allowed clinical staff to identify patients who were due to receive health checks and who may have overlooked them. We did not meet any people from this population group on the day of our inspection. Records held by the practice showed that 80% of patients, who had reported mental health conditions, remained stable with their treatment. The effective monitoring and review of these patients had resulted in this positive outcome

Summary of findings

Summary of findings

What people who use the service say

We met and talked with five patients who were members of the Patient Participant Group. They told us they thought the practice was well-led and that all staff were knowledgeable and caring towards patients.

Before our inspection we had left comment cards for patients to complete and drop into a box for our review. We found a number of cards were completed and all but one response was positive. The negative comment was about difficulties in securing an appointment with a GP.

During our inspection, an Expert by Experience got the views of patients attending the surgery for appointments on that day. Comments were collected from patients over the course of the morning. The majority of these were favourable and highly complementary of the services patients received. We noted from the NHS Choices website that there was a negative comment posted about reception staff. We asked the practice manager about

this who showed us how they deal with any complaints or negative feedback. We could see that formal complaints were reviewed by the practice manager and a GP who was a partner at the practice. Where appropriate, the practice made changes to reflect any learning from the complaint or issue raised. This echoed what we were told by the Chairman of the Patient Participation Group, which was that the partners of the practice did listen to and value the feedback of the patients.

The practice produced a quarterly newsletter and put it on its website. This was used to remind patients to book annual check-ups or their flu vaccination, and to alert people to any health specific campaigns, for example, blood pressure monitoring for people over the age of 40. Information on the NHS Choices website showed that 82% of patients would recommend the practice to another patient looking to register with a GP service.

Areas for improvement

Action the service COULD take to improve

There was limited analysis of the take-up of appointments among patients of working age, and the

timing of those appointments. This could help answer questions about difficulties experienced by patients in this group, in securing GP appointments outside of working hours.

Good practice

Our inspection team highlighted the following areas of good practice:

Staff at the practice had simplified on-screen forms that GPs had to complete during each patient consultation. This resulted in more 'face-to-face' time between patient and GP and improved patient experience.

Boughton Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC inspector. Our inspection team included a GP, a Practice Manager specialist advisor and an Expert by Experience. An Expert by Experience is a person who uses GP and other related services regularly.

Background to Boughton Medical Group

Boughton Medical Group is a practice located near Chester, Cheshire. It is part of the West Cheshire clinical commissioning group. At the time of our inspection the patient register contained 11,937 people. The practice is run by six partner GP's, a Managing Partner and a Nurse Practitioner Partner.

The practice was well staffed with five nurse practitioners, a salaried GP and administrative and support staff. The practice uses the Chester Extended Hours GP Service, which offers patients service between 6.30pm and 8.00pm Monday to Friday, and between 10.00am and 12.00pm on Saturday. This service is based at Countess of Chester Hospital. Emergency out of hours services are provided by an external provider.

Why we carried out this inspection

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

How we carried out this inspection

Our inspection was planned and we gave advance notice of the date we would visit the practice. In the two week period running up to the date of inspection, we requested copies of documents we would expect a practice of this size to have, along with records such as timing of any patient survey, minutes of staff meetings and records of any complaints received by the practice. We also requested a breakdown of numbers of patients in each population group. This helped us to focus on how these population groups were served by the practice.

The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

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

- Is it safe?

Detailed findings

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

We asked other organisations to share with us what they knew about the service. We carried out an announced visit on 28 May 2014. During our visit we spoke with a range of staff including two of the GP partners, the practice manager and the practice business manager, three administrative

staff and spoke with eight patients who used the service on the day we visited. We observed how patients were being cared for and talked with carers and family members. We spent time discussing the key areas of patient care delivered by each GP. We reviewed comment cards where patients shared their views and experiences of the service with us. We also spent time with members of the Patient Participant Group who discussed their role in ensuring the service met the needs of patients.

Are services safe?

Summary of findings

The clinical care of patients was safe. The surgery and all equipment was well maintained. There were systems in place to protect patients' safety, for example in infection control and review of medicines used. Clinical reviews were in place to help ensure that patients experienced the best possible outcome from their treatments. The practice showed us how it recorded and analysed any serious incidents, and how lessons were learned from them. The sharing of information that came from these reviews was clear when talking to staff and looking at agendas and minutes of staff meetings. There were processes in place to ensure that all GPs and other clinicians maintained their professional development. Support staff had the skills and knowledge required to enable them to carry out their duties correctly.

Our findings

Safe patient care

The practice was able to demonstrate how it managed and maintained partner specific clinical lead areas, and clear lines of accountability within the practice in relation to patient safety. We reviewed records of three serious incidents. We could see that investigations had been conducted into how each incident had occurred, what effect it had on patient safety, and how lessons learned were applied.

Working practices of nurse prescribers contributed to safe prescribing. Nurses returned to the practice to draw up prescriptions, on a system that would prompt them if a medicine may be unsuitable for a patient. Nurses could only prescribe within their specialism; any treatment outside of their specialist knowledge would be delivered by a GP.

The practice had met all its immunisation targets and benefited from strong record keeping and updating. This had helped the practice in running an 'MMR catch up' exercise, where people who may not have received immunisation for measles, mumps and rubella were contacted and offered the immunisation. The practice had a QOF (Quality and Outcomes Framework) manager, who helped use data to pro-actively contact patients who would benefit from certain immunisations, but who may have been missed by national campaigns. One good example of this was that girls in private schools were not routinely offered the HPV immunisation. HPV (Human Papilloma Virus) is responsible for cell changes in the cervix that can lead to cancer. As a result of a data search by staff at the surgery, the practice identified these patients and offered them the opportunity to receive the vaccine.

Learning from incidents

The practice had an open, transparent and learning culture when dealing with and reviewing any serious incidents, accidents or events. We reviewed two examples where a patient's diagnosis had been missed. The practice thoroughly reviewed the timeline from when the patient had consulted with a GP at the practice, through to diagnosis and referral to hospital, to see if things could have been done differently. The practice also looked at how communication with providers of secondary care, for example hospital out-patient clinics, could be enhanced to

Are services safe?

improve the chances of spotting any error in diagnosis in the future. As a result, GPs chase the progress of any hospital referrals to ensure secondary (hospital) treatment is given at the earliest possible point.

The practice had recently identified that a programming error in its IT system had wrongly classified some patients, which meant they may have been prescribed a medicine incorrectly. The practice informed the supplier of the IT system so that it could send a notification to other affected practices. Locally, it conducted a review of patients to identify those who had been incorrectly categorised and to address any inappropriate prescribing of medicine. We were able to confirm that no patients experienced harm due to this IT error.

Safeguarding

The practice had systems in place to identify to all clinicians, any child or vulnerable person that was subject to a safeguarding plan or deemed to be at risk. We found that staff followed the safeguarding policy of the practice in their day to day work which meant they understood the importance of safeguarding children and other vulnerable adults. Administrative support staff had a short-cut key on their desktop computer, taking them to instructions on how to raise a safeguarding concern. From records we could see that all staff had received safeguarding training. This was supported by on-line training updates and refresher training delivered in-house by the GP partner at the practice who was the lead on safeguarding of children and vulnerable adults.

We saw that when a child or vulnerable adult moved from the area and registered with another practice, all relevant safeguarding details were passed on. The requirement for GP's to attend meetings or produce reports for safeguarding boards had been met on each occasion it had been requested.

Monitoring safety and responding to risk

The practice had systems in place to identify people who experienced poor mental health, and who, possibly due to their health conditions could present with extremely challenging or violent behaviour. By having accurate markers on the records of patients, staff were able to better understand their needs and plan interventions accordingly. Importantly, this information was also made available to out-of-hours GP services.

Succession planning for the recruitment of key staff members was in place. The business manager for the practice was approaching retirement and steps were in place to recruit a replacement. This planning meant that key skills required to run a busy practice would be identified and looked for in any candidate recruited to the role.

The practice had an emergency drugs and equipment trolley which was kept in the main treatment room of the practice. We saw that all drugs for use in an emergency were in date; oxygen was also available for use and this was checked weekly alongside the emergency drugs. The practice also had a 'grab list', which could be completed with details of any emergency treatment given and sent with a patient to hospital.

The practice had comprehensive policies and procedures in place to deal with a variety of emergency situations, such as fire and evacuation of the building. Records we reviewed showed regular fire drills were carried out. Staff we spoke with knew what to do in the event of fire and how they would help evacuate patients from the building. The business continuity plan for the practice, explained how a variety of emergency situations, for example loss of power, would be dealt with. We saw that this had recently been tested and proved to be effective.

Medicines management

Medicines management was led and managed by one of the partners at the practice. This enabled any safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) or the European Medicines Agency (EMA) to be dealt with quickly and shared with all clinical staff, protecting patient safety and welfare. At the time of our inspection the GP prescribing lead for the practice was auditing and reviewing the prescribing of antibiotics. This showed that guidelines on best practice were re-visited on a regular basis, to ensure that patients experienced the maximum benefit from medicines prescribed correctly. There were systems in place to scrutinise any repeat prescribing to ensure that patients who required regular blood testing attended their appointments. This meant that any impact of medicines taken regularly was checked, for example the effect a medicine could have on liver function over time. The nurse practitioners prescribed only in their area of clinical specialism and this was monitored by GPs.

Are services safe?

Health care assistants regularly conducted checks on the drugs carried in doctors' bags. Checks included the 'use by' dates on drugs, and that standard items were replaced when necessary, for example, adrenaline. Records of drugs issued to GPs were kept and these were updated to show any items returned for destruction.

No controlled drugs were kept at the practice.

Cleanliness and infection control

We inspected the treatment rooms at the practice. They were well equipped, clean and tidy. The infection control nurse lead demonstrated a good level of contact and interaction with the infection control lead for the local clinical commissioning group (CCG). Treatment rooms were well stocked with protective equipment such as gloves, masks and aprons. All equipment for patients' treatment was for single use, so no sterilising or decontamination equipment was used. When we made checks on the sterility of disposable items, we found they were all within their 'use by' date. The infection control nurse shared with us a 'deep clean audit' that they carried out every six months at the practice. This was a tool shared by the CCG, and encouraged infection control audits to 'begin at the door of the practice'. In effect this meant the standard of cleaning in the building was checked rigorously every six months. In all the areas we visited there were hand washing facilities and all soap and hand sanitiser dispensers were full.

Staffing and recruitment

From our inspection we established that the practice employed staff who were competent and sufficiently qualified and experienced to carry out their duties. The practice had a good record in respect of patient safety and took all steps necessary to protect patients' welfare. People who worked at the practice had lead responsibilities for particular areas, such as medicines prescribing, medicines management, infection control, safeguarding and health

and safety. There were appraisal arrangements in place for all clinical staff and we saw that all staff were given support to maintain their levels of skills and expertise. This was mirrored among the administrative and support staff, who confirmed they had received regular training updates necessary to help them carry out their work.

The practice kept all patient records safely and securely; levels of access to these records was determined by the scope of each person's duties. When we checked staff files, we saw that all staff recruited had been referenced and had undergone enhanced background checks. These checks, which are made through the Disclosure and Barring Service (DBS) can confirm a person's suitability to work with vulnerable adults and children.

Dealing with Emergencies

The practice had a business continuity plan in place that was recently tested and found to be effective. The plan addressed a number of emergency situations that could occur, and how the practice would respond, for example in the case of loss of power or extreme weather conditions. The practice worked in a cluster of nearby practices that could offer support in the event of an emergency. When we spoke with staff about emergency situations, they were aware of the business continuity plan and could access the plan from their computer.

Equipment

The practice had an emergency drugs and equipment trolley, kept in the main treatment room. Records showed the equipment was properly tested and serviced, and that emergency drugs such as adrenaline were in date and ready for use. Staff were trained in the use of a defibrillator and the administration of oxygen, and this training was reviewed and refreshed regularly. The practice regularly checked and serviced equipment to ensure its safety and suitability for daily use, for example items such as scales and blood pressure monitors.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective in meeting the demands of a growing patient register. The patient register numbered almost 12,000 people and to accommodate patients' needs, the practice offered 'express clinics' each day. At these clinics people could be seen by a nurse practitioner who could help with a wide range of common illnesses such as ear and throat infections, chest infections and urine infections and prescribe medicines for these conditions. In the event that a patient needed further advice or consultation with a GP, the nurse prescriber could allocate an emergency appointment for the patient on that day. Patients we spoke with recognised the value of these clinics, particularly those who worked full time and needed to be seen quickly by a health professional. The practice worked hard to meet the needs of patients across all population groups. We particularly found that older patients were well supported by GPs and the practice nurses.

Our findings

Promoting best practice

One of the practice nurses we spent time with was able to describe how they met the needs of younger patients who wished to discuss contraception in a safe and confidential environment. A service was offered to younger patients between 4.00pm and 6.00pm. This was shown to be the optimum time for younger patients to come to the practice.

The practice carried out minor surgical procedures and the practice nurse had recently attended a training update on the insertion of contraceptive implants. When we asked questions around the provision of this service to younger patients the nurse was able to demonstrate knowledge around informed consent, the Mental Capacity Act, Fraser guidelines and Gillick Competency. All these references indicated an understanding of what current best practice in this area was, and that any treatment considered was in line with National Institute for Health and Care Excellence (NICE) guidance. The practice nurse told us they attended quarterly meetings of practice nurses across the Cheshire area, where best practice was shared and key findings discussed.

Management, monitoring and improving outcomes for people

There was evidence that care was effective, safe, responsive and well-led for patients with dementia. The management and monitoring of these patients was carried out from the early stage of diagnosis. Emphasis was put on 'benchmarking' patients early, which meant the rate at which the condition advanced could be monitored closely. The two nurse practitioner leads in this area had supported patients during their transition from older style treatments to other medicines. As a result, patients with dementia had experienced better health outcomes and relatives had commented on the positive changes they had seen in family members. A high-quality working relationship had developed between the nurse practitioners and geriatric consultants at the local hospital who had also supported their work. The nurse practitioners and GPs at the practice oversaw the physical health of these patients, to ensure wherever possible, hospital admissions from a care or home setting were minimised for these patients.

The practice had trained a member of staff to manage the computer based administrative work required by GPs and practice nurses. The QOF (Quality and Outcomes

Are services effective?

(for example, treatment is effective)

Framework) manager, had simplified computer based forms a GP must complete when seeing a patient, by identifying boxes that had to be ticked or questions that had to be answered. The result of this was more 'face to face' time for patients during the consultation, rather than a GP being focussed on entering patient responses to questions and other associated data. Also, the exercise conducted by the QOF manager ensured that critical activities during consultations, such as blood pressure checks were done and data entered onto the patient record. This in turn would feed any lists generated, for example, on people who should attend for more regular blood pressure checks.

Staffing

All staff, clinical and administrative, demonstrated a high level of commitment to the practice and to the patients they served. We saw good communication between the teams and a genuine respect for all colleagues and their contribution to ensuring the success of the practice.

An induction process was in place for all staff joining the practice, although staff turnover was very low. Appraisal arrangements were in place for all clinical and administrative staff. Staff we spoke with told us they were offered career development opportunities as well as sufficient support to maintain their professional development. We saw examples of how the practice used peer review of the GPs' work to identify any poor outcomes for patients, and any steps the practice had taken to deal with this. The practice held regular staff meetings. Minutes of these were kept so that absent staff could keep up to date with any changes or issues. Staff spoke of the supportive nature of their managers and the partners, and said they would feel comfortable reporting anything they felt compromised patient care, safety or well-being.

Working with other services

We saw several examples of how the practice worked well with other services. Two nurse practitioners and GPs supported local nursing homes. The practice held regular meetings with community health visitors and Macmillan nurses. This strengthened the communication between

community-based and practice-based care teams. The practice held a list of all people who were receiving palliative care and this was shared with out-of-hours services. There were strong processes in place to collate information received back from out-of-hours services and to update patient records in a timely way. This was critical in ensuring that GPs were able to review any treatment delivered to patients and to provide follow-up care if required.

Health, promotion and prevention

We saw examples of how the service delivered patient care effectively, especially to those who may overlook their physical health, for example patients with a learning disability or mental health conditions. Often, patients with a learning disability will only relate to people and professionals that they are familiar with and have seen previously. Continuity of care to these patients, from one or two specific GPs gave a great deal of reassurance to these patients and their carers and made it easier to deliver their treatment.

The practice ran a number of disease clinics, each one led by one of the five nurse prescribers. Patients registering with the practice completed a patient questionnaire which enabled those with chronic long-term conditions to be identified quickly and offered an appointment with the relevant clinician.

We saw how national catch-up campaigns such as the measles, mumps and rubella (MMR) vaccination programme were run efficiently, with text message reminders delivered to those who may be in need of this vaccine. People who may have been missed in national campaigns were contacted by support staff. This checking and re-checking of patient registers contributed to high take-up rates of such immunisations.

In the reception and waiting area of the practice there were a variety of health information and advice leaflets for patients to take away, and contact details for support organisations, for example, for those people who cared full time for a relative with terminal illness.

Are services caring?

Summary of findings

Patients told us the care they received was very compassionate and that they were always treated with dignity and respect. We saw an example of how the needs of patients' with learning disabilities were met and how continuity of care was protected by GPs and other staff at the practice in cases where this was key to a patient's successful treatment.

Our findings

Respect, dignity, compassion and empathy

We spent time talking to patients in the waiting area of the practice. People told us that they particularly valued the reception and administrative staff who showed them patience and understanding when looking to book their appointments with the relevant clinicians. One patient told us that following a recent diagnosis of cancer, they had received excellent support from all staff, to make sure they were seen regularly by the correct GP and that any community services were organised for them. Things such as repeat prescriptions and the collection and delivery of these were also organised.

One person we spoke with told us of the lengths GPs had gone to, to provide continuity of care from childhood into adulthood for a family member. The person told us that they felt supported as a carer, and they were confident that staff always acted in a patient's best interest.

The culture of respect between staff was mirrored in the way staff spoke to patients' and respected their privacy, confidentiality, consent and the right to make choices about their treatment. We saw how younger patients were actively encouraged to take responsibility for their sexual health and well-being. Nurses had made time available that was convenient for younger patients to attend appointments at clinics. Treatment areas were private and conversations between treatment areas could not be overheard. The practice had a chaperone service that was advertised in the reception and waiting areas. Nurses told us that they and health care assistants were trained in providing the chaperone service.

Involvement in decisions and consent

We found that nurses were very aware of the need to seek consent before offering any treatment. We asked a doctor at the practice to demonstrate how they sought consent, for example, before giving injections. The doctor was able to show that procedures were in place to gain consent for this. The GPs demonstrated an understanding of the Mental Capacity Act, the involvement of advocates, and how decisions would be reached in a patient's best interest.

The practice had records in respect of patients who were receiving palliative care. These were shared with district nurses and Macmillan nurses who supported patients in the community. Advance decisions were documented on

Are services caring?

whether a patient wished to be resuscitated in the event of cardiac arrest, whether they wished to be admitted to hospital during end of life care and how much detail could be shared with their primary carer.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had conducted some analysis on registration of new patients at the surgery. Results showed that the practice experienced a rise in the number of patients from other countries, many of whom needed interpreter services. The analysis showed that appointment times for patients in this group were longer, typically 20 minutes per patient as opposed to the allotted 10 minute appointment time, and that the number of consultations per year was double that of other patient groups. By conducting this research the practice was able to act in a responsive way to meet the needs of this patient group, for example by printing information in a range of other languages, increasing the level and range of interpreter services, scheduling slightly longer appointment times and ensuring staff were aware of the cultural needs of this patient group.

Our findings

Responding to and meeting people's needs

Patients we spoke to said that the services offered by the practice met their needs. We found examples throughout our inspection where the practice followed best practice guidelines in meeting people's needs.

Disease clinics were run to meet patients need to have their health conditions managed consistently over time. Access to confidential contraception advice for younger people was available to them at a time they were able to visit the practice. When we spoke with the Patient Participant Group, they told us they felt GPs at the practice listened to them and that the results from patient surveys were responded to.

Access to the service

Patients spoke favourably regarding access to the services offered by the practice. The nurse practitioner- led clinics made a considerable contribution to the amount of time GPs were available to deal with patients with acute problems or more serious health complaints. Patients registered with the practice who were from overseas, were given access to interpreting services and information in a format they could understand. We found older patients and patients with learning disabilities were well cared for and consideration was given to their issues around access and continuity of care.

The Patient Participant Group told us that patients found it difficult to contact reception staff in the mornings when they needed to book an appointment. We were told of plans to upgrade the current telephony within the practice but that this came at a considerable cost. Because of this, no firm date for the telephony upgrade had been committed to. The practice had invested in the further development of the premises to provide another two consultation/treatment rooms which would result in greater patient access to services. This underlined the commitment of the partnership to ensure access to healthcare services met growing demand.

Concerns and complaints

The practice had a complaints policy and process. We reviewed complaints that had been received in the past 12 months. Records showed how the GP partners and the

Are services responsive to people's needs?

(for example, to feedback?)

managing business partner had responded to each complaint. Evidence available demonstrated how lessons learned were shared with all staff and how any learning could be used to drive improvements.

Are services well-led?

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

Summary of findings

The practice was well-led, in clinical as well as administrative support services. Leaders were visible, approachable and accessible. There was an open, transparent culture of learning which led to improvement in patients' experiences of care. Innovation was encouraged and this had delivered real improvements in patients' care and welfare, such as dementia care in the community and the accessibility of services to patients with a learning disability. Any decisions were made inclusively and took account of the opinions of patients and people who worked at the practice.

Our findings

Leadership and culture

Throughout the practice across all staffing levels, we saw evidence of strong leadership that was visible, available to staff and welcoming of feedback, challenge and change. The managing business partner told us that GP partners allowed enough time for meetings to ensure that any issues, for example succession planning, were addressed and plans to support this drawn up. We were told that all items on an agenda were always addressed, regardless of time constraints.

The administrative support team were supported by their managers. Staff we spoke with told us they felt well looked after and above all, appreciated. Staff worked on rotation across various duties in the office which they felt kept them fresh and helped maintain enthusiasm for learning. The practice supported team building events and these were given as much importance as meetings. We observed how staff responded to patients when they arrived at the surgery. We saw that staff were respectful, courteous and compassionate with all visitors.

Governance arrangements

We looked at systems the practice had in place to minimise risk and promote high-quality care. Arrangements were in place to allow the nurse practitioners to prescribe medicines only within the range of their specialisms; where a nurse dealt with minor ailments such as sore throats, coughs and earache, they would only prescribe treatments within that field. We asked nurses and GPs if they had a prescribing protocol. We were told that the practice followed the protocol of the clinical commissioning group (CCG) when prescribing medicines. This ensured that medicines were only prescribed to treat an illness they were recognised and licensed for. The nurses we spoke with told us of the ongoing commitment the practice had made to their professional development which enabled them to deliver high-quality care to their patients.

One of the GP partners was the appointed governance lead for the practice. Any changes or updates to the law that affected the running of the practice were reviewed, and policies and procedures were amended in line with this for example, to reflect changes in laws governing health and safety at work. We saw that arrangements were in place to start handing over a number of key responsibilities, from the practice business manager who was due to retire, to

Are services well-led?

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

the practice manager and other staff. We saw that succession and staff planning was in place to ensure that no part of the departing staff member's role, which covered significant areas such as building and premises safety, business continuity and disaster recovery, were overlooked and that high levels of governance were maintained and supported.

Systems to monitor and improve quality and improvement

There was a regular programme of clinical meetings held by the practice. We saw examples of minutes from these meetings, although key action points and allocation to any one person was not clear from the records we reviewed. We saw two examples of well-structured clinical audit carried out by the practice clinicians in the past twelve months. We also saw how the lead partner of the practice carried out reviews of the progress of patients who were cared for by the practice nurses, for example, in the dressing and management of wounds and the speed of patient recovery. We saw evidence of follow-up to these audits, which meant results could be analysed to check effectiveness of treatments and whether they could be improved.

All GPs were subject to regular appraisal and review and appraisal arrangements were in place for nursing staff and administrative support staff.

The practice was able to show us a range of policies and procedures that were in place to help them maintain the consistency and quality of service they provided.

The practice had responded to the quantitative information it had access to with regard to demand for patient appointments. This showed the number of patient consultations had risen by 19% since 2005. The practice had invested in the further development of the premises to provide another two consultation/treatment rooms which would result in greater patient access to services. This underlined the commitment of the partnership to ensure access to healthcare services and meet growing demand.

Patient experience and involvement

All patients we spoke with told us they were happy with the service they received from the practice. They felt their GP listened to them and treated them with dignity and respect.

We noted that the last patient survey showed favourable results across all the areas covered. However, the results

for questions about the practice opening times came out slightly worse than expected. This data was from 12 months ago, but the Patient Participant Group were helping to develop a new patient survey to provide up-to-date feedback. At the time of our inspection the practice opening hours were between 8.00am and 6.30pm which afforded some appointments outside of working hours. Where people had complained about being kept waiting for a significant time beyond their appointment time, this had been investigated by staff. As a result, measures to reduce the instance of this were put in place quickly and demonstrated that patients were listened to.

Staff engagement and involvement

Staff told us they were well looked after, fulfilled by the work they did and appreciated the learning and development opportunities they were offered. Staff we interviewed confirmed they had annual appraisals and regular one-to-one sessions with their manager, which they felt had a real purpose and contributed to their feeling of being part of a team. At the time of our inspection staff rotated on duties around the office, which they felt kept them fresh and open to learning opportunities. Staff told us the management were inclusive in making decisions about how the practice would move forward, for example in advertising any opportunities that may arise when the existing practice Business Manager would retire. Although we did not see a whistleblowing policy, staff we spoke to could explain what the term whistleblowing meant and we were able to confirm that practices and procedures in place would support any whistleblowing incidents.

Learning and improvement

A system for the reporting and review of any serious incident or events was in place. We looked at a number of these as part of our inspection. From the examples seen and actions taken we could confirm the practice had acted and responded appropriately.

Learning from experiences was shared between clinicians. We saw examples of how GPs reviewed the speed of diagnosis of some patient's conditions and their referral onto secondary (hospital) care. These cases were reviewed to see if opportunities for quicker diagnosis and referral had been missed, or could be improved on in the future.

The lead partner GP had done some analysis work on the frequency of inappropriate discharges from secondary (hospital) care back to GP care, the lack of detail in patient discharge summaries and unexplained delays in patient

Are services well-led?

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

treatment which had resulted in significant events being documented. This allowed findings to be fed back at meetings of the clinical commissioning group in order to improve the effectiveness of joined up care for patients leaving hospital.

The levels of coaching and mentoring of staff at the practice was good. All staff took part in the performance and appraisal process and were aware of their individual and team objectives.

Identification and management of risk

As part of our inspection we discussed the identification and management of risk, particularly in respect of clinical practice. The partnership had recently undergone a change

in structure to accommodate absence. Throughout this change and appointment of other salaried GPs and locums, the practice lead partner had considered how clinical oversight would continue for all GPs and nurses who delivered treatment. There were clear lines of accountability between the GP lead in each area, for example prescribing, dementia and mental health, and the nurse practitioner leads in those areas. Likewise the work of practice nurses was reviewed and appraised by both a nurse prescriber and a GP. When speaking with nurse practitioners we particularly noted their ownership of risk. They understood that managing risk was everybody's responsibility.

Older people

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

Summary of findings

The practice was caring and responsive to the needs of older patients'. It had invested in advanced training for clinical staff that supported patients with dementia. After they were diagnosed, patients were supported and their progress followed for 12 months, something which had previously been identified as lacking.

There was also significant support for older patients' who still lived at home with the help of carers.

Our findings

Safe

Older patients told us they felt the care and treatment they received was safe. Two patients told us of times they had relied on the practice when a family member was receiving palliative care. Systems were in place to support patients who wished to receive end of life care in their own home. Practice relationships with other care professionals such as district and Macmillan nurses were good. This contributed to a high standard of palliative care.

Caring

Older patients we spoke with expressed their gratitude for the nurses, doctors and other staff at the practice. They told us that staff were patient with them when organising appointments at various clinics. One patient told us of the support they had received following a recent diagnosis of cancer. They explained how staff had helped organise follow-up appointments and other services that would be delivered to them in the community.

Effective

Nurse practitioners had carried out a significant amount of work to improve outcomes for patients with dementia. Specially trained nurses supported patients and their carers, from a diagnosis of dementia onwards. Relatives told us how they appreciated this support. Staff followed best practice guidelines to ensure that patients received the best possible treatment. Regular medicine reviews ensured that any drugs that no longer provided any benefit were withdrawn and more appropriate medicines prescribed. Carers of patients with dementia commented this had a positive effect on their relative.

Responsive

The service was responsive to the needs of older patients. Patients from this population group told us they experienced care and treatment that helped them maintain their independence; this was important to them.

Older people

The blood collection service on site was particularly important to them as they felt the journey to the local hospital was difficult and presented them with significant challenges if they didn't have a car.

Well-led

People from the Patient Participant Group (PPG) who represented the needs of all of the patients registered with

the practice told us the practice was well-led. They said that GP's attended their meetings and the managing Business Partner and GP partners were very approachable. The group thought the GPs were open to patient feedback on how the service could be delivered to meet the needs of the patients.

People with long term conditions

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

Summary of findings

The practice ran specialist clinics for patients with long-term conditions. Patients were seen by nurse prescribers who were specially trained to deliver treatment for chronic conditions such as diabetes and asthma, in line with recognised best practice. Data we reviewed before our inspection showed that hospital admissions from patients within this group were low. This suggested that the management of long-term conditions was effective.

The practice had its own blood collection clinic. Patients told us this was something they particularly valued. Although the decision to run the blood collection clinic was not based solely on the feedback of patients, we did see evidence that the practice had been responsive to patients' personal circumstances and access to such services had been considered.

Our findings

Safe

Patients who needed on-going treatment were well supported by staff. We looked at how patients with long-term conditions had their treatment and medication reviewed to ensure they experienced the best possible outcomes. For example, we looked at a recent audit of patients who could benefit from vitamin D supplements alongside their usual medicine. As a result the practice had contacted 13 patients and invited them for a review of their medicines. This showed that GPs and nursing staff consistently followed any medicines alerts or National Institute for Health and Care Excellence (NICE) guideline amendments, which meant that patients were receiving safe and effective treatments.

Caring

Patients who were attending blood collection clinics on the day of our inspection spoke highly of all the staff at the practice. One patient recently diagnosed with cancer told us of the way they had been supported by all staff, how services for them when they were at home were organised and generally how they were helped and supported by staff, following their diagnosis.

Effective

The five nurse practitioners each led on the management and treatment of a particular condition. They maintained up-to-date knowledge on how the condition was best treated over time. The data we examined before our inspection showed that unplanned hospital admissions of patients who suffered with chronic obstructive pulmonary disease (COPD) was slightly higher than the expected figure for a practice of this size. The practice had analysed this and could find no clear explanation as to why this had happened. The practice conducted follow-up

People with long term conditions

appointments with patients to see if there were any factors that influenced these patients' decline in condition. At the time of our inspection, the analysis was inconclusive but continuing.

Responsive

As the practice register had grown, so had the number of patients with chronic diseases attending the practice. This had affected the practice's appointment availability. The practice conducted a capacity analysis in June 2013. The volume of consultations had grown from 54,800 in 2005 to 64,800 in 2013. This meant that in the past eight years GP consultations had risen by 19%. This prompted a review of GP consultations. In 2006 up to 40% of GP consultations were not appropriate or the patient could have been seen by another healthcare professional. In March 2013 that figure had fallen to just 2.5% of inappropriate consultations with GPs. This was achieved through investing in staff training on how to query in a sensitive way, whether a patient needed to see a GP. Patients were better

'signposted' to other healthcare professionals, such as the nurse practitioner specialising in a particular condition. The practice had also increased its available appointments by 30 hours a week for an advanced nurse practitioner to see patients 'on the day'.

Well-led

We found that the practice was well-led. Each nurse practitioner reported to a lead GP in their area of speciality. The GP prescribing lead for the practice held regular meetings with nurse practitioners treating chronic diseases, to discuss particular cases and patient outcomes. As the demand for care and treatment of people with long-term conditions had increased the leaders at the practice had responded by listening to the concerns and ideas of the staff. This had led to a plan for the development of two new consulting rooms which the partners were funding. This would enable more patients to be treated by the nurses who might not otherwise have had access to a dedicated treatment room.

Mothers, babies, children and young people

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

Summary of findings

We saw a variety of health-care initiatives targeted at this population group. The practice ran ante-natal and post-natal care clinics, mums' and babies' clinics and publicised any 'catch-up' immunisation campaigns, for example measles, mumps and rubella (MMR) vaccination programmes.

Confidential contraception advice for young patients was available and this was advertised through social media, the practice website and through posters displayed in the surgery. The practice was able to demonstrate commitment to confidentiality of young patients' health matters and effective use of social media to reach patients in these age groups.

We found there was limited representation of patients from this population group on the practice Patient Participant Group (PPG). The group explained that recruitment of patients to represent these age groups was difficult. We discussed ways of reaching these patient groups and perhaps 'taking the group to them', rather than people having to make a commitment to attend a physical meeting. The group said they could explore options to help achieve this, for example using Skype or video conferencing facilities.

Our findings

Safe

The practice held regular child immunisation clinics. These were open from 8.00am to 6.00pm and new parents and their baby or child were not bound by a particular appointment time. This was useful for parents who worked and needed an early morning appointment. Health visitors ran baby clinics from the practice. These took and monitored babies' weights and offered advice and support to parents and their babies. The practice had a named lead health visitor who was at the clinic on a weekly basis.

Caring

At the time of our inspection, there were no parents with babies' attending the surgery. Staff told us that if an appointment was needed on the same day for a child that was unwell, as a minimum they would be seen by a nurse practitioner who would then refer them on to a GP if required. When we reviewed complaints received over the past 12 months, we found none were from new mothers or parents with young children.

Effective

Practice managers told us how health visitors operating at the practice provided invaluable face-to-face contact with the GPs. This was particularly useful if a very young child was not feeding properly or there were other health issues that health visitors had become aware of. Health visitors were also able to feed back information when the safeguarding lead GP was preparing a report for a safeguarding board.

The practice had taken steps to make sexual health and contraception services more accessible to younger patients. The nurse who ran these clinics told us younger patients appreciated the service, the fact that it was accessible between 4.00pm and 6.00pm, and that confidentiality was assured. The practice had also used the data it held on patients to target information on any

Mothers, babies, children and young people

immunisation campaigns they may have missed, for example for females wanting to receive the Human Papilloma Vaccine (HPV). This was also done in a way that protected patient confidentiality.

Responsive

We reviewed complaints received by the practice from people in this age group. We saw how the practice had responded to complainants on the day the complaint was made, for example in relation to services delivered by community clinicians. We saw how the practice signposted patients to the correct services and contacts, for example the community midwives office or health visitors to ask

them to help patients with problems that the practice did not deal with directly. This showed the commitment of the practice to ensure patients' needs were addressed quickly by the appropriate clinicians.

Well-led

The practice had systems in place to provide services to this population group, and took active steps to target patients who would benefit from any catch-up immunisation campaigns. It had thought about when younger patients would be able to attend any clinics, which had improved their access to services offered. There was very little representation on the Patient Participant Group (PPG) of mothers with very young children and of younger patients. The PPG told us that it was looking into other ways to reach out to these patients.

Working age people (and those recently retired)

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

Summary of findings

Patients we spoke with from this group said that overall they were happy with the service they received. Some patients we spoke with on the day told us that getting an appointment outside of working hours was always difficult and they wished that these appointments could be 'protected'. We asked patients if they were aware of the Patient Participant Group (PPG). There was limited awareness of this among patients of working age. This meant the practice may not be hearing some of the problems experienced by this age group. This supported the data we reviewed before our inspection where the score for 'convenient opening times' was lower than expected for a surgery of this size. At the time of our inspection no one at the practice had lead responsibility for investigating and addressing this issue, or looking at how other practices managed this very common problem.

Patients we spoke with were aware of the blood collections clinic at the practice and valued this service. One patient told us they particularly valued the Saturday morning flu clinics that the practice runs each year. Patients said they were confident in the clinicians they saw and felt the treatments they were given were safe and effective.

Our findings

Safe

We found care and treatment delivered to this population group was safe. Of the GP partners in the practice, there were three female GPs and three male GPs. This meant patients who wished to be seen by a doctor of the same sex could do so. The chaperone service was well advertised in waiting areas. The practice ran 'well man' and 'well woman' clinics, which targeted patients of working age who fell within age groups often linked to particular conditions, for example, to raise awareness about testicular cancer or breast cancer. The practice sent text messages to patients to encourage them to attend the surgery if they had any concerns about their health. This meant the practice followed national initiatives and took steps to protect patients' health.

Caring

Patients we spoke with told us they felt the service they received was caring, compassionate and that staff were always respectful and treated them in a dignified manner.

Effective

We were able to speak to a patient who had recently moved to the area. They had registered on-line with the surgery and were impressed by the service and how quickly they had been seen. They had seen a practice nurse for a health check as a follow-up to information given in their on-line patient registration form and were given an appointment to see a GP two days later. This showed that there was no unreasonable delay in patients receiving medical services when transferring from one GP practice to another.

Responsive

Comments in recent patient surveys and on comment cards submitted by patients before our inspection indicated that people from this population group experienced difficulties in getting appointments outside of normal working hours. We looked at the age breakdown of patients that the practice served. From the figures provided the working age group, specifically those people aged

Working age people (and those recently retired)

between 26 and 49 were the largest age group. However, the practice was unable to provide data on what proportion of appointments this group took up each week. This data would also have been useful to gauge whether appointments outside of working hours were being offered to and used by this group, and to show whether the practice was pro-active in meeting their needs.

Well-led

Overall the practice was well-led in relation to this age group. Some improvements could be made to enable

easier access to services. Comments had been made in a patient survey about appointments outside of normal working hours, and that getting through to the surgery on the phone was difficult. We were not made aware of any initiative to improve availability of appointments to this population group, or which member of staff in the practice was taking responsibility for trying to do so.

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

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

Summary of findings

We saw good examples of care delivered to patients who were, or could become, very vulnerable because of their health condition. Parents and carers told us about the care delivered by a GP at the practice, to patients who had a learning disability. They felt that the care and treatment delivered to these patients had been caring, effective, and responsive to their needs.

Our findings

Safe

The practice had a safeguarding policy in respect of children and vulnerable adults. This was understood by all staff we spoke with and we saw evidence of their understanding of the policy in their day-to-day work. For example, information held on the computer systems was available to out-of-hours practitioners in respect of any child, young person or vulnerable adult that was the subject of a safeguarding or protection plan.

Caring

We were told by carers that the practice was very good at helping people with a learning disability and other vulnerable people to maintain and look after their health. Carers told us the support of the GPs at the practice had been invaluable and that the people they cared for experienced positive health outcomes.

Effective

The GPs at the practice provided continuity of care to people with complex learning disabilities. GPs who led in this area of care and treatment explained how, over time, GPs and other professionals at the practice had built trusting relationships with the people receiving care. This enabled clinicians to better understand what these patients were experiencing when presenting with a condition. For example, the level of pain they felt if injured, or how symptoms they experienced affected them on a daily basis. This resulted in an improvement in this patient group's experience of medical services, which meant that patients with a learning disability experienced more positive outcomes.

Responsive

We were shown statistics that confirmed the rise in people from other countries who had registered with the practice recently. The practice had responded to this by ensuring

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

that patients who did not speak English had access to interpreter services, and were given sufficient time within appointments to communicate what their problem might be. There were stickers in the ladies toilet giving helpline information to patients who may be experiencing domestic violence or abuse. This showed that there was an awareness among staff, of patients who may come to the surgery with their own interpreter, who could not speak freely or seek the help they needed.

Well-led

We found that the practice cared for vulnerable groups of patients and worked hard to ensure care and treatment

was inclusive of all population groups. Analysis of patients registering with the practice recently had revealed that 19% of new patients were from outside the UK. Staff confirmed they had received training in equality and diversity which ensured they were aware of the cultural needs of patients from different population groups. Following further analysis of these results, the practice made available more interpreting services, more literature in languages other than English and longer appointment times to facilitate interpreter services.

People experiencing poor mental health

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

Summary of findings

A lead nurse practitioner at the surgery maintained a register of patients who experienced mental health problems. The register allowed clinical staff to identify patients who were due to receive health checks and who may have overlooked them. We did not meet any people from this population group on the day of our inspection. Records held by the practice showed that 80% of patients, who had reported mental health conditions, remained stable with their treatment. The effective monitoring and review of these patients had resulted in this positive outcome.

Our findings

Safe

We found patient care for people who experienced mental health problems was safe. We looked at clinical audits of patient care undertaken by the GPs in the past 12 months. One of these was the review of patients being prescribed a particular anti-depressant drug, and the risk it posed to patients over time if prescribed with other, common drugs. These patients were reviewed again as part of a follow-up exercise. The audit showed there was a significant reduction in any co-prescribing – that is prescribing with other drugs that could increase the chance of cardiovascular disease.

Caring

We found that the service provided to people was caring and compassionate. There were no complaints from advocacy services, or others who may support patients with mental health issues.

Effective

We found the way in which patients experiencing poor mental health were treated and cared for was effective. Staff maintained and updated records accordingly, and indicated if a person's health condition could result in challenging behaviour which ensured out-of-hours providers were protected from any potential harm. It also ensured that patients who may be distressed could be better understood by clinicians who were not familiar with their condition and medical history.

Responsive

We found staff were responsive to patients who experienced poor mental health. The data we reviewed before our inspection showed there had been no complaints from people or their advocates about access to services for mental health patients. One person we spoke with told us of the speed of response when they had needed primary (GP services) and secondary mental health

People experiencing poor mental health

services (hospitalisation) for a family member, and how they had also found all staff to be understanding, supportive and respectful at what can be a very difficult time.

Well-led

The practice maintained a mental health register which meant patients were known to all the GP's and clinicians at

the practice. This enabled the patients to get high quality care quickly and ensured their treatment was reviewed regularly. We saw several examples of clinical audit that were conducted to check patients experienced the best possible outcomes from their treatment and that best practice guidelines were checked for updates and followed.