Westcroft Health 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Westcroft Health Centre on 24 February 2015.

The practice achieved an overall rating of Good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

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.
- Information about services and how to complain was available and easy to understand.
- 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. The practice sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Ensure the role specific training update for the GP safeguarding lead has been completed as planned
- Review the infection control policy, the associated training and audit so control measures and lead roles are made explicit to practice staff
- Make all possible efforts to increase the membership of the Patient Participation Group (PPG)
- Ensure the new appraisal system is implemented and embedded across all staff groups
- Improve patient experience during GP consultation so they feel involved in their care and treatment
- Explore ways to manage the growing practice list size and create improved access to appointments for patients

Summary of findings

- Ensure policies and procedures reflect and comply with the requirements of legislation and directives

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 patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect. 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. However patients had expressed difficulty in obtaining appointments to see a GP through the NHS Choices website and the GP patient survey. 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 with staff and other stakeholders.

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. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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

Summary of findings

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.

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 and these patients had received a follow-up. It offered longer appointments for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care 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. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

The six patients we spoke with on the day and the comment cards left for us gave positive comments concerning the care and compassion shown by staff. Patients commented that the GPs and nurses offered an excellent service and noted that staff were friendly knowledgeable and helpful. Comments on the cards were positive about the care experienced.

The latest GP survey and comments left on the NHS Choices website showed that patients were generally dissatisfied with access to GP appointments. They reported that access was difficult and that they had to telephone early in the morning or afternoon to secure an appointment. They also reported that they experienced long waits before the telephone was answered by a receptionist.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the role specific training update for the GP safeguarding lead has been completed as planned
- Review the infection control policy, the associated training and audit so control measures and lead roles are made explicit to practice staff
- Make all possible efforts to increase the membership of the Patient Participation Group (PPG)
- Ensure the new appraisal system is implemented and embedded across all staff groups
- Improve patient experience during GP consultation so they feel involved in their care and treatment
- Explore ways to manage the growing practice list size and create improved access to appointments for patients
- Ensure policies and procedures reflect and comply with the requirements of legislation and directives

Westcroft Health 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 acting as specialist adviser.

Background to Westcroft Health Centre

Westcroft Health Centre provide a range of primary medical services for people in the western area of Milton Keynes, Buckinghamshire and serve a registered population of approximately 13374 patients. The practice population is predominantly white British but the practice also serves patients from ethnic minority groups.

Clinical staff at this practice include four GP partners, two salaried GP, a locum GP, three practice nurses and one healthcare assistant. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trust also provide a service at this practice. A mix of male and female clinical staff is available.

When the surgery is closed out of hours care is accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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

Detailed findings

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 5 February 2015.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the registered manager and other practice staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed 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

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts, quality of performance information as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, following an incident where a patient had become intimidating rude and aggressive, staff had referred the issue to GP partner who had reinforced the need to apply the practices' zero tolerance policy.

We reviewed safety records, incident reports for the past year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Lessons learnt and actions from analysis of significant events incidents and accidents were shared and discussed during staff meetings and staff training days and we saw evidence of this. For example a GP showed us how the practice had strengthened their system for reviewing patients who needed medication changes following the receipt of a particular blood test result. Receptionists, nursing and other staff knew how to raise an issue for consideration at meetings and they felt encouraged to do so.

National patient safety and medicines alerts were received by the registered manager and reviewed by the practice nurse who uploaded these into the practice intranet and shared with staff appropriately to ensure they were noted and acted upon.

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 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.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. The GP lead told us that their role specific safeguarding training update has been arranged to take place shortly. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. Contact details and referral pathways were clearly visible in each consultation room.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and people who were housebound.

We saw that the practice team had regular monthly meetings with the health visitor, and other clinical and relevant staff to discuss ongoing safeguarding issues and agree plans for keeping patients safe. Issues discussed included those affecting children, elderly and other vulnerable groups and domestic abuse. The safeguarding lead or a nominated representative attended child protection case conferences and reviews where appropriate.

A chaperone policy was available and staff we spoke with confirmed that chaperoning was usually carried out by clinical staff. Designated non clinical staff also acted as chaperones and we saw records that showed that they have been trained to act as a chaperone.

Medicines management

There were systems in place for managing medicines safely. We saw that all medicines that were in general use were securely stored in locked cupboards or refrigerators as appropriate and were only accessible to authorised staff.

There was a policy for ensuring medicines stored in refrigerators were kept at the required temperatures. This was followed by the practice staff and staff described to us the action to take in the event of a potential failure.

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 were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance and we saw evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Individual blank prescription sheets and computerised prescriptions sheets were tracked through the practice and kept securely at all times.

We reviewed the repeat prescriptions system in use at the practice. Repeat prescriptions requests could be made by patients online or by written request at the practice. There was a repeat prescription review process in place, which meant patients that used medicines over longer periods were required to attend for periodic reviews with their GP before they continued taking the medicine to make sure it was still appropriate treatment for them.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning was regularly checked by the registered manager. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There was a lead for infection control who told us that they had undertaken further training to enable them manage and provide advice on infection control. However we did not see any record of this training. All staff received induction training about infection control specific to their role but we did not see any records of regular training updates. The infection control lead told us that they had carried out an infection control audit last year but we were not shown any evidence that supported this.

An infection control policy was available but did not give explicit instructions which would enable staff to plan and implement measures to control infection. However we found that personal protective equipment including disposable gloves, aprons and coverings were available, and staff were able to describe how they would use these to maintain effective infection control throughout the practice. Privacy screens around examination couches were of the disposable type and we saw evidence that these had been changed recently. Hand washing sinks with hand soap and hand towel dispensers were available in consultation and treatment rooms. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had carried out a risk assessment for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings) and found the risk was low and no additional action was required.

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and equipment used to record the electrical activity of the heart called the electrocardiogram (ECG).

Staffing and recruitment

We reviewed the practice's recruitment policy and found that it was not explicit on the employment checks required by schedule 3 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, such as obtaining proof of identification, references, checks on qualifications, and registration checks with the appropriate professional body.

However records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

Staff 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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Good

Are services safe?

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 registered 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Staff carried out periodic checks to ensure there were adequate equipment stocks and out of date items were removed and reported to the practice nurse.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example patients with chronic obstructive pulmonary disease (COPD) were shown effective inhaler techniques and given a COPD rescue pack so they could anticipate and prevent exacerbations of this condition and avoid unplanned hospital admission. There were emergency processes in place for identifying acutely ill children and young people. The practice access policy ensured children under the age of 5 yrs would be seen on the day by a GP or a nurse.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen. Staff knew the location of the equipment and records showed it was checked regularly. A hazardous substance warning notice was not displayed on the door of the room where oxygen was stored. Following our inspection the practice manager wrote to us and told us that this notice was now displayed.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency medicines were within their expiry date and suitable for use. The emergency medicines we checked were clearly labelled, in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of heating, and loss of the telephone or computer system. All staff had access to the plan. Key contact names and telephone numbers were recorded in it. For example, contact details of a heating company to contact if the heating system failed.

Records showed that staff was up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. Patients had their needs assessed and their care planned and delivered in line with published guidance, standards and best practice such as those published by the National Institute for Health and Care Excellence (NICE) and those from their local commissioners.

The GPs told us that they used protected learning time and the weekly clinical meetings to discuss clinical issues with patient care to ensure the appropriate care and referral pathways were followed so that there was no delays to their care and treatment and we saw evidence of this.

The GPs told us they lead in specialist clinical areas such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) and skilled practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

We reviewed data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices nationally and data demonstrated that thepractice had achieved a high number of patients within the target range for controlling hypertension.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example for data management and managing child protection.

The practice had a process for completing clinical audit. Clinical audit is a way of identifying if healthcare is provided in line with recommended standards, if it is effective and where improvements could be made. We saw evidence of how the practice had used clinical audit in this way. The practice showed us seven clinical audits that had been undertaken in the last two years. One audit showed that the practice had checked if antimicrobial prescribing for upper respiratory tract infection was as recommended by national guidelines. Following this audit the practice had introduced further training for prescribers so all prescriptions met the national guidelines. Another audit had been carried out on patients 65 years of age and over that were prescribed regular antidepressant. This had shown a number of patients who received this medicine had required a review to discuss whether to continue with this treatment. Both audits are scheduled for re audit in the near future.

The practice had a palliative care register and had regular internal as well as multidisciplinary case review meetings where the care and support needs of patients and their families were discussed. Every resident that lived in a care home had a care plan and a named GP to coordinate their care.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example the practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease (lung disease), and dementia care reviews. However the practice was an outlier for monitoring patients with diabetes. The lead GP told us that this was due to the diabetic nurse leaving but monitoring had now recommenced and the practice intended to meet the targets by April 2015.

The practice participated in local benchmarking run by the local clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example the practice had participated in a financial planning project with CCG.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding or booked on appropriate refresher courses.

Good

Are services effective?

(for example, treatment is effective)

The registered manager told us that the practice had just replaced their appraisal system with a new one and had a schedule to appraise all staff using this system by the end of this year. The nurses and other staff told us they felt able to discuss any training or development issues at any time.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, practice nurses and healthcare assistants seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were also able to demonstrate that they had appropriate training to fulfil these roles and had attended protected learning time sessions or dedicated training.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. GPs had a scheduled programme for revalidation. The practice nurses were supported to attend updates to training that enabled them to maintain and enhance their professional skills.

The practice had a process to manage poor performance both for clinical and non clinical staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice received either electronically or by post diagnostic test results, such as blood test results and letters from the local hospitals including discharge summaries and out-of-hours GP services when patients had used these services. Staff were clear of their responsibilities and other staff responsibilities in dealing with this correspondence and acting on any issues arising from communications with other care providers on the day they were received. A patient's GP was normally responsible for taking any action for these results. If this GP was unavailable the GPs had a duty system where they would check each other's results to ensure urgent actions were dealt with promptly. We were told of no instances within the last year of any results or discharge summaries that were not followed up appropriately.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This included regular meetings with professionals such as health visitors to discuss child health and safeguarding issues and with MacMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. They also liaised with the out of hours service and provided detailed clinical information about patients with complex healthcare needs. There were regular discussions with other professionals that worked in the community, for example the community matron and the district nurse so unplanned hospital admissions from care homes could be reduced.

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 through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported this system was easy to use and recognised some patients may find the system complex to use and would provide further support to these patients.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is provided electronically to healthcare staff that treat patients in an emergency or out of hour's situation which enabled them to have faster access to essential clinical information about that patient. The practice planned to have this scheme fully operational during 2015.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained to use the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Staff we spoke with

Good

Are services effective?

(for example, treatment is effective)

understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs had received Mental Capacity Act training but no other clinical staff. Patients with a learning disability and those with a form of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing.

The GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice offered minor surgery and had a process to obtain written consent before this procedure was performed. A GP told us that a record of the relevant risks, benefits and complications of the procedure would also be made in the patient's records at the same time.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

All new patients were offered a health check when they registered with the practice. The health check included a review of the patient's history of illnesses, lifestyle and current medicines. Following their new patient health check patients were referred to the in-house health promotion programmes such as the smoking cessation programme.

The practice offered a range of immunisations, childhood and adult to protect people from a range of diseases in line with current national guidance. Last year's performance for childhood immunisations was slightly below national average. There was a procedure for following up non-attenders.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with a learning disability and they had received an annual physical health check. The practice had identified the smoking status of patients over the age of 16 and had encouraged them to attend the smoking cessation clinics held weekly. Similar mechanisms of identifying 'at risk' groups were used for patients with high blood pressure and or elevated blood cholesterol. These groups were offered further support in line with their needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. These included information from the GP patient survey and comments left on NHS Choices website. The evidence from these sources showed patients experiences were mixed with most reporting satisfaction with their experience of care. For example information from the GP patient survey showed 70 % of respondents reported the GP was good at listening to them and 62% said the GP gave them enough time with 84% expressing confidence and trust in the GP. Ninety-one percent of the respondents also expressed confidence and trust in the nurse they saw. The satisfaction levels are lower than expected when compared with other GP practices in the local area.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the care experienced. Patients comments that the GPs and nurses offered an excellent service and noted that staff were friendly knowledgeable and helpful.

We spoke with six patients. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed that patient involvement in planning and making decisions about their care and treatment could be improved. For example, data from the GP patient survey showed 57% of practice respondents said the GP involved them in care decisions and 63% felt the GP was good at explaining treatment and results. The satisfaction levels are lower than expected when compared with other GP practices in the local area.

Patients we spoke with 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 comment cards we received was also positive and aligned with these views.

Older people over the age of 75 had a named GP to agree and coordinate their care. People living in care homes had a care plan agreed with them.

There was a very small proportion of patients whose first language was not English. The practice had access to a translation service provided by the local council.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day and the comment cards we reviewed gave positive comments concerning the care and compassion shown by staff.

Notices in the patient waiting area and the practice website gave information on how to access a number of support groups and organisations. Patients were able to be referred to the local assessment and short term intervention (ASTI) team for common psychological problems including depression, stress and anxiety.

The practice's computer system alerted GPs if a patient was also a carer. There was related information available for carers on the practice website to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or by giving them advice on how to find a support service.

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 patient'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.

The registered manager told us that they were aware of the growing practice list size and were currently reviewing how this impacted on the number of appointments the practice was able to offer.

The practice had taken account of the views expressed through the GP patient survey and the NHS Choices website and had introduced a new system to improve access to GP appointments. This included a GP patient triage system when same day appointments were exhausted, bookable appointments for consultations the next day, the facility to book appointments online, and telephone consultations with the GP . The practice was monitoring the effectiveness of this system with a view to making further improvements.

The practice delivered a number of specific enhanced services to support the needs of the local population. These included smoking cessation, health checks, contraceptive implants, minor surgery and looking after vulnerable patients. Enhanced services require a level of service provision above what is normally required under the core GP contract.

The practice maintained register of all patients in need of palliative care or support irrespective of their age so their care and support were arranged and provided in a timely way.

The practice had responded to the needs of the practice population and operated extended hours on Mondays to ensure they were available for students, commuters and working people.

For families, children and young people, appointments were available outside of school hours.

People whose circumstances may make them vulnerable could see a GP of their choice. A designated area by the reception desk was available should they wish to discuss their needs in private.

The practice operated a virtual patient participation group (PPG). The uptake of the PPG had been slow and the registered manager told us that they were taking steps to encourage patients to enrol for this virtual group.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff we spoke with had a good understanding of equality and diversity. Any specific issues were discussed at practice meetings and staff were actively asked for their opinions and views.

Staff told us that they felt their views were listened to and felt comfortable raising concerns or queries about inequity and or promoting equality either on a one to one basis, in appraisals or in a larger staff meeting.

There were facilities for the patient who used a wheelchair such as fully automated doors at the main entrance to the practice, same level flooring throughout, clinical and consultation rooms available on the ground floor and a toilet for patients with disabilities including grab rails and alarm. The practice had disabled parking available.

The practice maintained a register of patients aged 18 or over with learning disabilities and provided an annual health check for these patients. Practice staff told us that flexible appointments in terms of time and length of appointment times could be accommodated based on the patient's specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice took a flexible approach when providing to the needs of the individual. The practice maintained a temporary register of asylum seekers with health needs and provided care for these patients while more substantive arrangements were sought.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Consultations with GPs were available from 8.30 am to 11.30 am in the morning and from 3 pm till 5.30 pm in the afternoon. The practice offered extended hours on a Monday evening till 8.30 pm. Nurse led clinics were scheduled throughout the day. The practice's extended opening hours on Monday evenings was particularly useful to patients with work commitments.

When same day appointments were exhausted, the practice offered telephone triage by a GP who then assessed if the patient needed to attend the practice for further review and treatment. Patients assessed as high risk, such as young children were always seen on the same day.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes and to those patients who needed one.

Through the GP patient survey and the NHS Choices website patients had expressed dissatisfaction with the appointments system. For example on the NHS Choices website only 32% of the patients rated their experience of making an appointment as good or very good and a similar number 33%, said the same through GP patient survey. Patients we spoke with and comments left for us in the comment cards told us of similar difficulties in obtaining an appointment.

The registered manager told us that the practice had introduced improved systems to increase access to GP appointments. This included a GP patient triage system when same day appointments were exhausted, bookable appointments for consultations the next day, the facility to book appointments online, and telephone consultations with the GP . The practice was monitoring the effectiveness of this system with a view to making further improvements.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw a poster in the reception area that gave information to help patients understand the complaints system. The practice website had a facility for patients to make a comment or suggestion, which also advised to contact the surgery should they wish to make a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw the practice had received 14 complaints in the last 12 months and found these had been satisfactorily handled and in a timely way. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

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

Our findings

Vision and strategy

We spoke with seven members of staff on the day and they were clear about their vision to deliver quality evidence based care that promoted positive outcomes for patients. Their aim was to promote an open and honest culture which supported the development of an effective professional team.

Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us that they felt very involved and were consulted in regard to any changes or improvements planned. They told us that ideas for improvements were encouraged and were often discussed during staff and practice meetings. A GP told us that they were developing a business plan which would incorporate the need for succession planning due to impending staff retirements.

Governance arrangements

The practice had a clinical governance policy which showed the decision making processes in place. Staff at the practice were clear on the governance structure. For example, the practice nurse was the lead for infection control and a designated GP was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. They understood that the GP partners worked with the registered manager in making decisions about how the practice delivered its services.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five and all were current. Two of the policies we looked at, recruitment policy and the infection control policy were not explicit in the detailed requirements for its effective implementation.

The practice had arrangements for identifying, recording and managing risks. The partners' meeting was used to review and take action on all reported incidents, events including clinical events and complaints. We looked at minutes of the meetings which demonstrated this happened as and when required. Details of any discussions and decisions made in those meetings were made available to all staff through a range of staff meetings.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Seven clinical audits had been undertaken in the last two years and we saw evidence of improvements made to care as a result.

Leadership, openness and transparency

Practice team meetings were held at least monthly and all staff were invited to attend. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The registered manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through GP patient surveys, NHS Choices website, the complaints process, and their own website. We looked at the results of the GP patient survey and noted that the practice was working to improve access to GP appointments.

The practice gathered feedback from staff through a variety of methods such as, staff meetings, appraisals, one to one supervisory meetings and practice training days. There were high levels of staff satisfaction. Staff told us of the open and facilitative culture that promoted a positive working environment. They were happy to give feedback and discuss any concerns or issues with a GP colleague and or the registered manager.

The practice operated a virtual patient participation group (PPG). The uptake of the PPG had been slow and the registered manager told us that they were taking steps to encourage patients to enrol for this virtual group.

Management lead through learning and improvement

Are services well-led?

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example the practice nurse had undergone additional training in the management of chronic obstructive pulmonary disease (COPD). Two staff we spoke with told us that they had an appraisal within the last 12 months. The registered manager told us that the practice had just introduced a new appraisal system and that the remaining staff would be appraised using this new process by the end of this year.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. GPs took responsibility for writing up and cascading the learning from these events.

The practice organised protected time learning at least once a month. The practice closed one afternoon per month to facilitate this training. The registered manager organised a full training programme for this learning in conjunction with the clinical and other practice staff.