Lyme Valley Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lyme Valley Medical Centre on 15 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they had access to appointments and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider should:

- Continue to monitor and improve patient access to appointments and their preferred GPs.

Record the regular checks carried out by staff on the defibrillator.

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. 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 the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal learning plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said that staff were caring and helpful. They told us they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We 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. Most patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Some patients told us that they had difficulty getting an appointment and others did not have access to their preferred GP. The practice were aware of these issues and were taking action to improve these services for patients. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. 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 on the at risk register. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with other professionals such as health visitors.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Care was tailored to patients' individual needs and circumstances including their physical health needs. Patients who presented with anxiety and depression were assessed and managed within the National Institute for Health and Care Excellence (NICE) guidelines. Annual health checks were offered to patients who had serious mental illnesses. GPs had the necessary skills and information to treat or refer patients with poor mental health. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed.

Summary of findings

What people who use the service say

We reviewed 34 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that all comments were extremely positive about the staff and the care and treatment received. Patients told us that all of the staff, including the receptionists were always very professional, respectful and treated them in a dignified and caring manner. They said the nurse and GPs listened to them and they did not feel rushed. They confirmed that they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Two patients wrote that they sometimes had difficulty getting an appointment.

The results from the National Patient Survey 2014 showed that 89% of patients felt that their overall experience of the practice was good and 97% said that the last appointment they got was convenient. The practice, in conjunction with the patient participation group (PPG) had carried out annual surveys to assess patient satisfaction. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. We saw that action plans were developed as a result of patient feedback.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- continue to monitor and improve patient access to appointments and their preferred GPs.
- record the regular checks carried out by staff on the defibrillator.

Lyme Valley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Lyme Valley Medical Centre

The Lyme Valley Medical Centre is located in a purpose built primary care medical centre. It is situated in Newcastle-under-Lyme, Staffordshire and serves the local population by providing general practitioner services.

The practice has four GPs, two male and two female, a GP registrar, a practice manager, a nurse practitioner, three practice nurses, a health care assistant, a senior administrator and administration and reception staff. There are 6084 patients registered with the practice and the practice is open from 8am to 8pm Monday to Friday.

The practice treats patients of all ages and provides a range of medical services. This includes a number of services such as reviews for asthma, diabetes and chronic obstructive pulmonary disease (COPD). It also offers child immunisations, contraception advice and travel health vaccines.

The practice is a teaching practice supporting GP registrars and medical students from Keele University. It does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

The CQC intelligent monitoring information placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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:

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, 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 15 January 2015. During our visit we spoke with a range of staff, two GPs, a GP registrar, a nurse practitioner, a practice nurse, a healthcare assistant, two medical students, the practice manager, the senior administrator, a receptionist and the medical director. We reviewed 34 comment cards where patients and members of the public shared their views and experiences of the service and spoke with the chair and former chair of the patient participation group.

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 and national patient safety alerts 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.

We reviewed safety records and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the period.

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. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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 carers and children identified at risk of harm.

There was a chaperone policy available to all staff and information on the availability of a chaperone for patients in the waiting room and on the practice website. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All reception staff had been trained to act as a chaperone by the practice manager. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

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

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.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines

Good

Are services safe?

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that other staff had also completed infection control training specific to their role. We saw evidence that the lead for infection control and the practice manager carried out annual infection control audits and improvements identified for action were completed on time.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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.

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. Staff told us that GP locums were used to cover GP holidays when necessary and every attempt was made to use the same GP locums where possible to provide continuity of care for patients.

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 annual and monthly checks of the building, the environment, medicines management, dealing with emergencies and equipment. The practice also 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.

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: staff we spoke with gave us examples of referrals made for patients with a long term condition, diabetes, whose health deteriorated suddenly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. Records confirmed that the oxygen was checked regularly, however we did not see a record of the regular checks carried out by staff on the defibrillator.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart stops beating), anaphylaxis (severe allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan and disaster pack 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, unplanned sickness and access to the building. The documents also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Clinicians told us that NICE guidelines and the associated implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with confirmed this, however they told us that these discussions were not always documented and this was an area for improvement. Staff confirmed that any actions taken in relation to NICE guidelines were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as chronic disease, palliative care and prescribing and the practice nurses supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened and that there was strong team work at the practice.

We saw evidence of data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was better than the CCG average. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review all patients with a care plan who were discharged from hospital, which required patients to be reviewed to see if further admissions could be avoided.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. For example all GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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

We saw that clinical staff actively participated in quality schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The CCG is the NHS body responsible for commissioning local NHS services. We were shown the latest QOF achievements that told us practice staff were mostly meeting or exceeding the required targets and national standards.

The practice showed us three clinical audits that had been undertaken in the last 12 months. One of these was conducted in relation to suspected skin cancer referrals. The aim of the audit was to ensure that all referrals made were following national guidelines, and to look at the percentage of cases resulting in a correct diagnosis of malignancy. We saw that a second cycle audit had also been completed as a follow up. This included: a review of how many of the cases that had been referred had been examined using a dermatoscope (a device used to examine the skin), whether this had resulted in a decreased number of excisions or biopsies, whether a significant number of cases avoided biopsy by the use of a dermatoscope and if this could strengthen the case for using a dermatoscope in general practice. The outcome of the audits demonstrated that the practice continued to follow National Institute for Health and Care Excellence (NICE) guidelines in suspected skin cancer referrals and patient outcomes remained in line with a study published in the British Journal of General Practice. The audits found that the use of the dermatoscope appeared to reduce the need for biopsies, and to make the case for more widespread usage, both in primary and secondary care.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine

Good

Are services effective?

(for example, treatment is effective)

health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. We also saw that there were regular meetings with the pharmacy advisor to discuss patients' medicines and where necessary, changes were made to prescribing as recommended by the pharmacy advisor.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and records showed that it had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

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

All staff undertook annual appraisals that identified personal learning plans for future training needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example menopause training for one of the nurses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We saw that the practice had regular meetings with the local Clinical Commissioning Group. Minutes of these meetings showed discussions took place in relation to both clinical and organisational priorities. The lead GP told us about a local peer review system they took part in with three neighbouring GP practices. We saw that as part of this monthly meetings took place which were minuted and showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs or children who were at risk of harm. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We also saw minutes of meetings with the pharmacy advisor and saw that there was a strong relationship and information sharing between the two parties.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. The

Good

Are services effective?

(for example, treatment is effective)

system included a facility to flag up patients who required closer monitoring such as children at risk. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice also had an electronic system to communicate with other providers, for example, a shared system with the local GP out-of-hours provider and accident and emergency (A&E) department to enable patient data to be shared in a secure and timely manner. An electronic 'Choose and Book' system was in place for making referrals. (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).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff were able to demonstrate how they would support a patient where capacity to make decisions was an issue for them, for example a patient with dementia.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal or written consent was documented in the electronic patient notes. We also found that the consent policy included details on how staff should seek consent from a patient for permission to have medical students present during their consultations with the GP.

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

Patients who were due for health reviews were sent a reminder and if necessary contacted and asked to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. This ensured that GPs were aware of the wider context of their health needs.

We were told that if patients failed to arrive for their childhood vaccinations reminders were sent out to parents. The most recent data available to us showed immunisation rates were mostly in line or above the average for the CCG requirements.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, we saw that the practice kept a register of all patients with a learning disability (14) and practice records showed that most of them had received a check up in the last 12 months. The practice offered nurse-led smoking cessation clinics to patients who smoked. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84%, which was average performance within the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. There was also a named nurse responsible for following up patients who did not attend screening. We saw a robust monitoring system in place for this.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was generally above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of 196 patients undertaken by the practice's patient participation group (PPG) in February and March 2014. The evidence from all these sources showed patients were satisfied with how they were treated and the services provided by the practice. For example, data from the national patient survey showed that 89% of patients who responded felt the overall experience of the practice was fairly good or very good. The practice was well above average for its satisfaction scores on consultations with GPs and nurses with 95% of practice respondents saying they had confidence and trust in the last GP they saw or spoke with and 99% had confidence and trust in the last nurse they saw or spoke with. Of those who responded 84% said the last GP they saw or spoke to was good at listening to them and 83% say the last GP they saw or spoke to was good at giving them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 34 completed cards and all feedback was positive about the staff and the care and treatment received. Patients told us that the staff were always very helpful and professional and treated them in a respectful and dignified manner. Two patients wrote that they sometimes had difficulty getting an appointment.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultations took place behind closed doors so they could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that the reception area was suitable to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed that 75% of practice respondents felt the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. 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.

Patient/carer support to cope emotionally with care and treatment

Patient feedback in the CQC comment cards showed that staff were compassionate when patients needed help and emotional support. One patient said that when they had a recent bereavement they had been given leaflets about how to get support from a bereavement counsellor. We saw that these leaflets were in the reception area of the practice.

The practice's computer system alerted GPs if a patient was a carer and identified patients that were cared for. We were shown the written information available for carers to ensure that they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patient satisfaction surveys. This included updating the surgery décor and taking steps to improve access to appointments via the online appointment booking facility.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example patients with a learning disability or temporary residents.

The practice had a very small patient population from ethnic minority groups, however there was access to interpreter and translation services for those patients whose first language was not English.

We saw that the practice had an equality and diversity policy and that most staff in the practice had completed equality and diversity training. Staff we spoke with confirmed that they had completed the training and were aware of how to support patients with diverse needs.

The premises and services were designed to meet the needs of patient with disabilities. The practice was situated on the first and second floors of the building with all services for patients on the first floor. The practice had wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8am each weekday and appointments were available from 9am to 12pm and 3pm to 6:20pm every Monday and Wednesday, from 10:30am to 2:30pm and 3pm to 8pm every Tuesday and from 9am to 12pm and 3pm to 6pm every Thursday and Friday.

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 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 111 service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. However the national GP survey 2014 showed that only 42% of patients who responded usually got to see their preferred GP.

Home visits were made to a number of local care homes and services as and when required. We spoke with representatives from three of these services whose clients were registered with the practice. They told us that they sometimes had problems obtaining an appointment for their clients, however when they did see a GP, they were very responsive to the client's needs. One representative said that they felt that the GPs who were long standing were much better at understanding and meeting the needs of their clients. They felt that some of the locum GPs had less understanding of the needs of their clients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. The national GP patient survey for 2014 showed that 97% of respondents felt that the last appointment they got was convenient which was above the local CCG average of **94%.** Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same

Good

Are services responsive to people's needs?

(for example, to feedback?)

day of contacting the practice. Other patient feedback from the patient satisfaction survey in 2014 showed that two of the key areas for review were: access to appointments and continuity of the GPs. We saw that the practice were aware of these issues and were taking steps to improve them.

The practice's extended opening hours on a Tuesday evening until 8pm and online appointment booking facility was particularly useful to patients with work commitments. This was confirmed by comments from two patients in feedback in the Care Quality Commission (CQC) comments cards.

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 that information was available to help patients to make a complaint on the practice website and in the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at 11 complaints received in the last six months and found that these had been satisfactorily handled and dealt with in a timely way.

The practice did not appear to review complaints annually to detect themes or trends or to share with staff the overall findings from complaints made. However, we saw that policies and procedures were updated as a result of complaints made and lessons had been learned from individual complaints. We saw that no complaints had been sent to the Ombudsman. Complaints were discussed regularly at practice meetings, for example at monthly administration meetings. This ensured that all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and values to deliver high quality care and promote good outcomes for patients. The vision was 'To develop our business and our staff in order to become a leading provider of primary and community health services, that is at the forefront of designing and delivering a broad range of high quality, diagnostic and treatment services to the communities we serve'. The practice's shared values were seen to be: Quality, Integrity, Empowerment, Responsibility, Leadership, Collaboration and Innovation.

We saw that the mission statement was detailed as: 'To deliver high quality clinical services to the communities we serve'. We saw that the mission statement was shown on the notice board in the main corridor of the practice. Staff told us that the practice had a five year business plan which was developed with them and representatives from the patient participation group at team away days.

Governance arrangements

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 eight of these policies and procedures and saw that most had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior GP was the lead for safeguarding and palliative care. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The leads for clinical leadership within Network Healthcare Solutions was the medical director (a practicing GP, GP trainer and examiner) and the director of nursing and clinical governance (a practicing nurse practitioner who provided advice and peer support for all staff.

We saw that regular clinical governance meetings were held at Lyme Valley Medical Centre and attended by all clinicians which were minuted and circulated to the clinical team. This included a monthly clinical executive meeting that considered all issues of clinical governance and clinical quality. We saw that risk assessments and managing risk was discussed at these meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was generally performing in line with or above local Clinical Commissioning Group and national standards. The practice had achieved over 99% of all available QOF points for the last two years. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We saw that the practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw one audit had been carried out on skin cancer referrals and on the prescription of a controlled drug used to relieve pain.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that regular team away days took place.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example an induction policy, which was in place to support staff. Staff told us that all policies were available to all staff on the practice intranet site. 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 patient surveys and complaints received. We looked at the results of the annual patient survey and saw that the key areas for review were: access to appointments, GP continuity, the impact of being a training practice and practice refurbishment. We saw as a result of this the practice had begun to address the access problems and work had commenced to ensure there was a balance between booking over the telephone and having the ability to book online.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG

Are services well-led?

Good

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

included representatives from various population groups; for example patients with a long term condition and older people. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff on the practice intranet.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal learning plan. Staff told us that the practice was very supportive of training and that they had staff away days which they found valuable.

The practice was a GP training practice for GP registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students. There was a lead GP responsible for the induction and overseeing of the training for the GP registrars and medical students. During the inspection we spoke with two medical students who told us that they felt well supported at the practice and were enjoying the experience of working at Lyme Valley Medical Centre.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and to ensure the practice improved outcomes for patients. For example we saw one significant event recorded about a prescribing error. Records showed the actions that the practice took in response to the error and the preventative measures to reduce the likelihood of it happening again.