

Staveleigh Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Staveleigh Medical Centre on 21st April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Majority of patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Following our previous inspection the practice had made all the required improvements in medicines management required under the Health and Social care Act 2012.

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?

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 informally 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.

Good



Are services effective?

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. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported on occasion's difficulties in accessing appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity.

Good



Summary of findings

There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework. This means they work, as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people, GPs, nurses and health care assistants provided home visits.

We saw care plans were in place for patients at risk of unplanned hospital admissions.

The practice had achieved 73% vaccination rate for the influenza vaccine.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has a register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so the condition can be monitored and reviewed. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns. Same day appointments were provided for children who were unwell.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged via the telephone.

The practice 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.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with 13 patients. We reviewed 33 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the

results of the GP national survey carried out in 2013/14 and noted 85% described their overall experience of this surgery as good and 92% had confidence and trust in the last GP they saw or spoke to.

In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services) We saw in February and March 2015, out of a total of 15 responses, ten selected extremely likely that they recommend the GP practice to friends & family if they needed similar care or treatment.

Staveleigh Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Staveleigh Medical Centre

Staveleigh Medical Centre provides primary medical services in Stalybridge from Monday to Friday. The practice is open between 8:30am and 6:00pm Monday to Friday.

Staveleigh Medical Centre is situated within the geographical area of NHS Tameside Clinical Commissioning Group (CCG).

The practice has a GMS contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Staveleigh Medical Centre is responsible for providing care to 6680 patients of whom, 50% were male and 50% were female. Patients are from the fourth most deprived decile with 7% black and minority ethnic (BME) patients.

The practice consists of five GPs, two male and three female, a practice nurse, two health care assistants and a phlebotomists. The practice was supported by a practice manager, office supervisor, receptionists and secretaries.

Staveleigh Medical Centre is a training practice, accredited by the North Western Deanery of Postgraduate Medical Education and has a GP registrar on placement.

When the practice is closed patients were directed to the out of hours service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme and to follow up on one area of non-compliance from a previous inspection in May 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 21st April 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

Detailed findings

We spoke with 13 patients and 12 members of staff. We spoke with a range of staff, including GPs, practice manager, practice nurse, health care assistant and reception staff.

We reviewed 33 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

- Is it well-led?

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

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

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place to monitor patient safety utilising all the data and information available to them.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk. Staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that action had been taken. Significant events were discussed within practice meetings. Learning was identified and improvements agreed, however a follow up evaluation of the improvements was not evident to monitor the outcomes.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice had systems in place to respond to safety alerts, in which the practice manager would disseminate to GPs for action and these would be discussed and actions agreed during weekly meetings.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, including regular contact with other health and social care professionals where required.

We saw patients who required annual reviews as part of their care; a system was in place to ensure reviews took place in a timely manner.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records, minutes of meetings and speaking with staff investigations had been carried. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurse told us they received regular updates as part of their ongoing training, and self-directed learning and attending practice nurse forums.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection policy and procedure and following our last inspection a policy was in place for vulnerable adults. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead; they had completed training to level three and met regularly with health visitors to discuss any child safeguarding issues. Staff had completed child safeguarding training to the appropriate level and staff including the lead GP had completed adult safeguarding training.

The practice linked with the Local authority, health visitors and district nurses to monitor vulnerable patients and attended where possible multi agency case conferences. Speaking with staff at the practice they were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside health visitors and social workers. We noted staff were vigilant of patients who may be at risk of domestic violence, and where it was known a patient was a victim of domestic violence alerts were placed within patient's records.

A chaperone policy was in place, Speaking with staff who acted as chaperones, they were clear of the role and responsibilities.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

Are services safe?

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

During our last inspection in May 2014 we found medicines to be out of date in GPs bags that were used for home visits. We found the practice did not have an effective system in place for checking the medicines in GPs bags used for home visits to ensure medicines were in date. As part of this inspection we found improvement with robust checks now in place and medicines in GPs bags were in date and safe for use

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. The practice worked alongside the clinical commissioning group, medicines management team who visited the practice to look at prescribing within the practice and audit medicines such as antibiotics and Benzodiazepines to support the practice in ensuring they are following up to date prescribing guidance.

The practice had shared care protocols in place for patients prescribed Disease-modifying antirheumatic drugs (DMARDs) normally prescribed for rheumatoid arthritis. For those patients prescribed warfarin the practice had an INR machine on site using the INR star software to allow them to manage in house warfarin dosage. The INR machine monitors how quickly blood clots using a measure known as the international normalised ratio (INR). The INR enables the dose of anticoagulant to be adjusted if required. This in turn can help prevent major bleeding, heart attack or stroke that can result from an over- or under-dose of anticoagulant.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or

following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by GPs were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was found to be clean and tidy. A nurse took the lead for infection control completing annual update training and carried out annual infection control audits including hand washing.

Cleaners were employed by the practice who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw the dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe

Are services safe?

environment. The infection control lead had completed infection control training and delivered updates for staff. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

Panic alert systems were installed in all clinical rooms to enable staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of three staff. We saw newly recruited staff checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We saw that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff and the practice had carried out DBS checks for all staff within the practice.

Monitoring Safety & 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. 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.

The practice manager had responsibility for all maintenance contracts and risk management associated with the building including the Control of Substances Hazardous to Health (COSHH). Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

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 and records confirmed that it was checked regularly.

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, anaphylaxis and hypoglycaemia. 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.

Staff were able to clearly describe to us how they would respond in an emergency situation for example over the telephone or face to face if a patient said they were experiencing chest pains, we noted within reception and all clinical room guidance was clearly displayed from the Resuscitation Council informing staff on action to take should a patient require resuscitation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions

Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The 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.

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. The staff we spoke with and the evidence we reviewed confirmed that these actions 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 nurse that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Speaking with the GPs, practice nurse and health care assistant they explained to us how they reviewed and supported patients with chronic diseases such as asthma and diabetes on an annual basis, we saw from The National Quality Outcome Framework (QOF) the practice had met 100% of the outcomes for patients with Chronic obstructive pulmonary disease (COPD), 100% Chronic kidney disease, 100% Asthma and 97% diabetes, all above the local CCG and national average.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks. All patients with learning disabilities were offered annual reviews with a health care assistant, in the practice or via home visits, using a nationally recognised template to ensure a comprehensive review was carried out encompassing emotional and physical wellbeing. As a result of the reviews during 2014/15 the practice identified patients with high BMI, diabetes and hypertension. The health care assistant supported patients with weight management programmes and where it had been identified some patients had not attended for smear test, where appropriate they were supported to do so.

The practice carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF provided evidence the practice were responding to the needs of people with poor mental health, , by ensuring for

example they had a comprehensive care plan documented in the record and patients had access to health checks as required such as, a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nursing told us they received regular updates as part of their ongoing training and attending monthly practice nurse forums.

Clinical staff were able to describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for referrals, sending referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically. We were told referrals were working well and the practice checked and tracked all referrals to make sure they are all done promptly.

Discrimination was avoided when making care and treatment decisions. Interviews with staff 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.

Staff and patients had access to telephone interpreter translation services and staff were familiar with how the service operated.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included

Are services effective?

(for example, treatment is effective)

data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and office supervisor to support the practice to carry out clinical audits.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were shown two audits which included an audit of Tramadol prescribing. Tramadol is used to treat moderate to severe pain.

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic obstructive pulmonary disease (COPD). Assessments were carried out for patients with COPD and where required seasonal adjustments were made which included prescribing rescue medication to help when a patient was experiencing exacerbation.

Nursing staff took the lead in supporting patients to manage their long term health conditions such as, asthma, diabetes and chronic obstructive pulmonary disease (COPD).

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 95% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nurses with a number having additional training and qualifications for example diabetes care and nurse prescribing. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. 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.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw the nurses had access to training as part of their professional development, attending training and practice nurse events in which updates on key issues was provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals

Are services effective?

(for example, treatment is effective)

to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. The GP and the practice manager arranged multi-disciplinary meetings where required. Communication on a daily basis with community midwives, health visitors and district nurses took place by telephone and fax.

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 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.

For patients at the end of life the practice worked closely with Macmillan and district nurse to ensure co-ordinated care was in place. Patients who required emotional support would be referred to counselling services.

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. The practice sent referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on 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.

The GPs described how the practice provided the 'out of hours' service with information, to support, for example, 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers.

For the most vulnerable 2% (a nationally agreed percentage) of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers to monitor patient welfare and provide the best outcomes for patients and their family. The practice had care plans in place for 2% of patients to help prevent admission to hospital.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations.

We found clinical staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). The doctors had received training on the Mental Health Act and MCA. We were told patients with Deprivation of liberty approval in place (DOLs) or requiring DOLs were increasing and the practice had identified this as a future training need.

Staff had access to Mental Capacity Act 2005 guidance which outlined the five core principles. A checklist was in place to ensure staff were following best practice procedures when assessing patient's capacity to consent. Guidance was also available for staff where a patient wished to make an advance decision. All staff told us where they had concerns about a patient's capacity; they would refer patients to the GP.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person's understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. The practice had a Gillick competencies

Are services effective?

(for example, treatment is effective)

checklist for staff to refer to if they were unsure about the process to follow. Where capacity to consent was unclear staff told us they would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were offered an appointment for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion.

We were provided with details of how staff promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

NHS Health Checks were offered to all patients aged 40 to 75 years. Since April 2014, 50% of those invited for health checks took up the opportunity. The practice followed the guidance from the local CCG to ensure patients followed in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The health care assistant provided patients to maintain healthy lifestyles by providing weight management support

and smoking cessation. The practice also referred patients to a community health improvement team who provided a range of healthy lifestyle support in the community and outside of normal hours.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had provided 73% of patients over 65 with the flu vaccination during 2014 winter campaign.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). We saw from the Quality and Outcomes framework (QOF) 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up children who did not attend for immunisations by the practice nurse, who liaised with health visitors.

Prior to our inspection we noted from data the practice's performance for cervical smear uptake was 78% just below local average but higher than the national average.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception staff would pass onto GPs and where any follow up was required staff would arrange an appointment or home visit.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with 13 patients and reviewed 33 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. We noted information was also displayed in the waiting area highlighting teenager's rights to confidentiality. Patients were provided with an opt out if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from reception and areas accessible to the general public to maintain patient confidentiality.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms at the side of reception. Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 89% of respondents found the receptionists at this surgery helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones, modesty sheets to maintain patient's dignity.

We found all rooms had dignity screens or lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see the GP or the nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GPs and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey showed 97% of respondents had confidence and trust in the last nurse they saw or spoke to, 92% said the last nurse they saw or spoke to was good at explaining tests and treatments and 92% had confidence and trust in the last GP they saw or spoke to.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 90% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate slightly below the local and national average. Care plans were in place for those over 75 years of age including those patients who lived within residential or nursing care and for those patients identified as vulnerable of unplanned hospital admissions. For those vulnerable patients at risk of unplanned hospital admissions care plans were in place and these were reviewed by GPs on a regular basis. Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions.

We noted that where required patients were provided with extended appointments for example reviews with patients with learning disabilities or multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carers support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 84% of respondents stated the last GP they saw or spoke to was good at listening to them and 85% stated the last GP they saw or spoke to was good at treating them with care and concern.

The practice had identified within their patient population a number of patients who were carers and had carers established a carer's register. We saw information for carers was readily available in the waiting area and on the practice website.

Are services caring?

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved patients were referred to a counselling service where required.

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 practice worked with patients and families and in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a newly formed Patient Participation Group (PPG). The PPG met formally for the first time in April 2015 and were looking at ways to increase patient engagement and feedback. We met with three members of the PPG who were positive about the practice and told us they felt welcomed and involved in its development.

The practice carried out an annual patient experience surveys as part of the GPs appraisal process. We noted from the 2014/15 survey 83% of patients rated the practice as good, very good or excellent. The practice put in place an action plan to address areas of improvement, such as appointment text reminders 24 hours before appointment.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice was over two floors with all patients accessing services on the ground floor. The practice was accessible

for patients with disabilities. A disabled toilet was available as were baby changing facilities. A hearing loop had been installed within the practice to support patients who were hard of hearing.

A telephone translation service was available for patients.

The practice provided extended appointments where necessary and appointments were available between 8:30am and 6:00pm Monday to Friday enabling people to make appointments out of normal working hours.

Access to the service

The practice was open between 8:30am and 6pm Monday to Friday. Patients were able to make appointments in advance, in person at reception or by telephone. On the day emergency appointments were available by telephoning the practice, arriving at the practice or booking online. Where all appointments were filled, reception staff would take patients details which would be followed up by the GP on call and where required same day appointments or telephone consultations would be arranged.

Patients were generally satisfied with the appointments system. They confirmed in the main that they could see or speak to a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. We saw all children under five would be seen on the day as would vulnerable patients either by telephone consultation, appointments at the practice or home visits.

We saw from the GP national survey 82% of respondents found it easy to get through to this surgery by phone and 87% of respondents were able to get an appointment to see or speak to someone the last time they tried, above the local average. 80% describe their experience of making an appointment as good. The practice provided data which showed they provided 1671 face to face GP appointments in March 2015 an average of 418 per week, in addition to face to face appointment telephone consultations were also available.

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. Home visits were available for patients each day by telephoning the practice before 10:30am.

Are services responsive to people's needs?

(for example, to feedback?)

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed, this information was detailed on the practice website and included information on the urgent care centre which could treat minor injury or illness. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were available for patients who needed them for example those with long-term conditions or patients with learning disabilities. This also included appointments with a named GP or nurse.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learnt were shared with staff at team meetings.

We saw a complaints leaflet which was available to patients at reception and within the practice leaflet, a feedback form could be submitted by the practice website.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

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 to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's mission statement and statement of purpose. The practice mission statement included, 'Our aim is to deliver consistent, high quality health care in partnership with our patients by having an effective and supportive team who are committed to working together.' Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality. We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with 12 members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation.

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 a senior partner was the lead for safeguarding. We spoke with 12 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.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) and the national patient survey to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them, using the data to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance.

The QOF data for this practice showed it was performing in line with national standards and just below the local and national averages in for both clinical and public health outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken, examples included minor surgery and checks to determine adherence to current guidelines for the management of Gout.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, significant events, new guidance, quality and risks had been discussed.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Full practice meeting held annually. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures, for example, a recruitment policy and induction programme were in place to support staff. We were shown the staff handbook that was available to all staff, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good 

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

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

The practice had gathered feedback from patients through the internal patient surveys via the patient participation group, national patient survey, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff during team meetings.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 85% described their overall experience of the practice as good. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services). We saw in February and March 2015 15 out of a total of 15 responses, ten selected extremely likely, two selected likely and three selected extremely unlikely that

they recommend the GP practice to friends & family if they needed similar care or treatment. Majority of comments were extremely positive about the care and treatment patients had received.

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 whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We noted staff annual appraisals were up to date and staff told us that the practice was very supportive of training and development opportunities.

The practice had reviewed significant events and other incidents and shared formally with staff during team meetings.