Craig Croft 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

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them. We carried out an announced inspection on 13 November 2014.

We found that the practice was safe, effective, caring, responsive and well-led. We rated the practice overall as good. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- There were systems in place to deal with complaints and protect adults, children and other vulnerable people who used the service.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice was proactive in promoting good health.
- Patients were treated with dignity and respect. Patients spoke positively about their experiences and the care and treatment provided by staff.
- Although the facilities were located in temporary accommodation in portacabins they were fit for purpose and adjustments were made to meet the needs of the patients.
- We found that the service was well led with well-established leadership roles and responsibilities with clear lines of accountability. The practice had a clear vision and set of values which were understood by staff.

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

The provider should:

- Improve information sharing with other agencies to ensure better safeguarding of children.

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 was rated as good for safe. There were effective infection control and medicines management policies and procedures in place. The practice ensured that significant events were documented and analysed and resultant learning shared. Staff used appropriate procedures to safeguard patients. Systems were in place for sharing relevant safety information with the staff team. The practice met quarterly with other safeguarding leads from other practice locally to learn and exchange information. However, the practice did not hold regular multi-disciplinary meetings with other professionals such as health visitors and school nurses.

Are services effective?

Good

The practice was rated as good for effective. There were effective arrangements to identify, review and monitor patients with long term conditions and those in high risk groups to ensure their needs were assessed and acted on. The practice had a range of health promotion leaflets and staff were actively involved with promoting patient's health. A system was in place to check the professional registration for all clinical staff. Opportunities were available for staff to undertake professional development. Staff appraisal had taken place which set targets that were aligned to the practice's key performance indicators.

Are services caring?

Good

The practice was rated as good for caring. Patients were complimentary about the staff at the practice and said they listened, gave them sufficient time to discuss their concerns and were understanding of their needs. Patients told us that their privacy and dignity was respected and they were involved in making decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive. The practice had arrangements in place to respond to the needs of the practice population. These included services aimed at specific patient groups. The service was located in temporary accommodation in portacabins but these were fit for purpose and were accessible to a variety of patients with different health needs. The practice had a system in place to respond to complaints and concerns in a proactive manner.

Summary of findings

Are services well-led?

Good

The practice was rated as good for well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. Leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the provider had systems in place for assessing and managing risks and monitoring the quality of service provision. There was evidence of improvements made as a result of audits and feedback from patients.

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 was rated good for older people. All patients over 75 years, including those living in care homes had an allocated GP and designated care plans were in place for at risk patients so that their care needs could be better co-ordinated and monitored. Home visits were available for those older patients who were unable to attend the practice. Patients were able to book and order repeat prescriptions online from their own homes. This was useful for those who had limited mobility. The GPs carried out monthly 'ward rounds' in local care homes with care staff in order to manage patients' health needs. These patients or their carer could directly contact the practice on a dedicated telephone number so that their call could be attended to promptly. This ensured patients' needs were met.

People with long term conditions

Good

The practice was rated good for patients with long term conditions. Patients with long term conditions were reviewed by the GPs, the practice nurses and at the chronic disease management clinic to assess and monitor their health condition so that any changes needed could be made promptly. Patients on repeat prescriptions were reviewed to assess their progress and to ensure that their medications remained relevant to their health need. The appointment system was flexible and allowed pre-bookable appointments. Patients who missed their reviews, especially for asthma, were called by the practice so as to understand their reasons for not attending and they were offered reviews by telephone. Same day and urgent appointments were also available which allowed better management of patients with long term conditions.

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. Mother and baby eight week checks were undertaken at the practice and midwife clinics were held. Immunisation clinics were held for childhood vaccinations. Through our discussion with GPs and patients we found children and young people were treated in an age appropriate way and their consent to treatment was sought using appropriate methods. There was evidence that the practice understood their patient population and the challenges they faced. However, systems in place to share information about children or adults at risk with external professionals were not held formally.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice was rated good for the care of working age patients (including those recently retired). A number of clinics and services to promote good health and wellbeing were available for all patients. Emergency appointments, telephone consultations and extended hours of surgery were available three evenings a week. This enabled patients who worked to attend after working hours. NHS health checks were available for people aged between 40 and 74 years and text appointment reminder system had been introduced to remind people of their appointment. Staff interacted with patients in a respectful, considerate and confidential manner and there was a private area for speaking if required, patients were informed of this. Patients were able to book appointments and order repeat prescriptions online from their own homes. This was useful for working age patients who may have difficulty attending the practice through work and other commitments.

People whose circumstances may make them vulnerable

Good

The practice was rated good for the care of people living in vulnerable circumstances. Patients who were vulnerable due to their health or social circumstances were offered health checks. GPs provided home visits to vulnerable patients who were unable to attend the surgery for urgent care needs. Appropriate information was shared and referrals were made to relevant agencies and health care professionals to ensure their health and wellbeing. There was a multidisciplinary approach to sharing information but this did not occur regularly. The practice had access to interpreting service for patients whose first language was not English and the practice website could be read in many other languages.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated good for people experiencing poor mental health (including people with dementia). Patients on the mental health register were invited for annual medical reviews. Reminders and alerts were added to patient records if the patient was at particular risk due to mental health needs. Patients were referred to other supportive services where appropriate. Medication with the potential for misuse was prescribed for seven days only or shorter as appropriate. More medication was only prescribed after further reviews. Information was shared with other services and information and signposting was available through the practice website and leaflets in the surgery. A screening tool was available for patients to help with diagnosis and assessment of the severity of depression.

Summary of findings

What people who use the service say

We spoke with seven patients who used the service in person and we received 21 completed comment cards. All but one of the comments cards were positive about the practice and staff overall. However, 11 of the comment cards commented on how it was often difficult to get an appointment with the GP of their choice. The same eleven cards also reflected a difficulty in getting through to the practice by telephone.

Almost all the patients we spoke with were positive about their experience but some also commented on the difficulty of getting an appointment. However, those patients we spoke with that had complex needs told us that they could get an appointment easily. For example, one patient told us that they found it easy to get an appointment given their specific health need. All of the patients said the GPs and nurses were knowledgeable about their health needs.

We also spoke with three managers of care homes. We were told that patients were able to get an appointment when required and home visits were available on the day requested if they called in the morning.

We spoke with three members of the practice's patient participation group (PPG). The PPG is a way in which patients and GP practices can work together to improve the quality of the service. There were eight members in the PPG and they told us they volunteered after seeing posters advertising for members. We were told that the practice was receptive to feedback from the PPG. The PPG members gave us examples where they had an impact on the way the service was delivered.

A patient survey was undertaken in the last year and the findings were analysed and responded to with follow up actions. The survey revealed patients were generally positive about the service.

Areas for improvement

-

Action the service SHOULD take to improve

- The practice should improve information sharing with other agencies to ensure better safeguarding of children.

Craig Croft 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 and a practice manager specialist advisor.

Background to Craig Croft Medical Centre

The practice provides General Medical Services to a population of approximately 10400 patients.

The practice moved into its current temporary accommodation at 139 Dunster Road in June 2012. New premises are due to be built and work was due to start in the near future. The practice is situated in an area with high levels of deprivation.

The practice is open Monday to Friday 8am to 6.30pm. Extended opening hours are available on three evenings, Tuesday, Thursday and Friday until 7:45pm, 7:30pm and 7:00pm respectively. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Badger, an external out of hours' service.

The GP team consisted of three partners (two male and one female) and five salaried GPs (four female and 1 male). The practice also employs three Practice Nurses, two healthcare assistants and a team of administrative staff.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit

Detailed findings

on 13 November 2014. During our visit we spoke with a range of staff including two GP partners, the practice nurse and various members of the administration team. We also looked at a range of documents that were made available to us relating to the practice.

Good

Are services safe?

Our findings

Safe track record

Significant events were recorded, analysed and discussed at staff meetings with an aim to take account of any lessons to be learned. A health and safety policy and risk assessments were in place and we saw a quiz developed and completed by staff to ensure they understood key health and safety issues.

Patient safety alerts are nationally issued when potentially harmful situations are identified and need to be acted on. We saw examples where alerts had been received and had been reviewed for any necessary action.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A flow diagram illustrating the actions to take in the event of significant events was in place. A significant event analysis template was available, this included prompts for discussion, actions taken as well as suggestion to prevent recurrence. We saw evidence of quarterly analysis of all significant events that were discussed at practice meetings with lessons learned and actions taken shared with all staff. For example, we saw there were nine actions following significant analysis from December 2013 to February 2014. One of the actions was to ensure all of the clinical team use the 'contraception template' when issuing contraceptives. This template had been updated recently so that if emergency contraception had been sought by a patient, it could be documented.

We saw evidence that safety alerts were responded to and investigated where appropriate. We spoke with a Clinical Commissioning Group (CCG) pharmacist who worked with the practice once weekly and they told us that the practice worked well with them and followed any recommendations they had made.

Reliable safety systems and processes including safeguarding

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening.

We looked at four staff files and saw that staff had received relevant role specific training on safeguarding with clinical staff trained to the appropriate level. Staff we spoke with were aware of how to recognise signs of abuse in older people, vulnerable adults and children. We saw that there was a safeguarding policy in place and staff were aware of this policy which included flow charts of referral processes. Contact details for making a safeguarding referral were also easily accessible to staff. There was a system in place so that management would be aware of those staff requiring training updates. We saw training was scheduled for some staff identified as requiring updates. The practice had a safeguarding lead GP and a lead nurse who other staff referred to for further information and guidance.

We saw a system was in place to highlight vulnerable patients on the practice's electronic records. This ensured staff were aware of any relevant issues when patients attended appointments; for example children who may be at risk of abuse. The safeguarding lead GP and the nurse lead attended monthly practice meetings to discuss any safeguarding issues with rest of the practice staff. However, the practice did not hold regular multidisciplinary meetings with other professionals such as health visitors and school nurses to discuss children at risk. Formal multidisciplinary meetings were held on an ad hoc basis. We were told that safeguarding leads mostly communicated safeguarding issues with health visitors, social services and other professionals mainly on the telephone.

A chaperone policy was in place and notices alerting patients to this were displayed.

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. The GPs we spoke with told us that they asked the nurses to act as chaperones, then the healthcare assistants (HCAs) and then the reception staff in that order. We did not see evidence that background checks via the Disclosure and Barring Service (DBS) checks were in place for administration staff carrying out chaperoning duties. Also, no risk assessments were in place for any administrative staff as to why a decision was made not to carry out DBS checks. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. However, we were informed after the inspection that all staff had undergone DBS checks.

Medicines management

Good

Are services safe?

Appropriate arrangements were in place for the safe storage, checking and handling of medicines. We observed medicines were stored, checked and records maintained in line with legal and safety requirements.

There were two dedicated secure fridges where vaccines were stored. The nurse was responsible for ensuring regular checks were undertaken and recorded of the fridge temperatures. This provided assurance that the vaccines were stored within the recommended temperature range and was safe and effective to use.

As part of stock control, staff routinely checked and recorded the expiry dates of medicines held in the practice.

There were systems in place to ensure patients had regular reviews of their medicines. Reception staff were unable to issue repeat prescriptions before the due date. We also saw that security arrangements were in place for prescription pads to protect against any potential misuse.

Cleanliness and infection control

The practice was located in temporary accommodation in a portacabin that looked visibly clean, tidy and fit for purpose. Patients told us that they found the practice to be clean.

The practice had an infection control policy with a designated lead. We saw that the policy was reviewed in February 2014 and contained details of audits carried out. Where appropriate actions were taken to address findings of the audit. However, some of the actions identified in the audit were deferred until the practice moved to a permanent site. We also saw evidence that all staff had attended infection control training.

There were sufficient hand washing facilities for staff and patients. Staff had access to the necessary personal protective equipment such as gloves and aprons when undertaking clinical procedures.

We saw a legionella management policy was in place and legionella and water testing was carried out and documented in line with guidance.

Equipment

We saw from practice records that equipment such as those used for blood pressure monitoring and emergencies were regularly serviced and maintained. The checks included the annual testing of all electrical equipment and fire protection equipment such as fire extinguishers. There was a policy for calibrating and inspecting medical equipment. We saw certificates that medical equipment such as scales, electrocardiograms (ECGs) and spirometers were calibrated so that the practice could be confident in their functioning and operation.

Staffing and recruitment

We looked at four staff files to check recruitment practices. We found that the practice had undertaken a number of checks regarding the suitability of staff. Suitable candidates were asked to provide documentation to confirm their identity and qualifications. These included references and proof of qualifications or registration with the appropriate professional body. Criminal records checks via the Disclosure and Barring Service (DBS) were available for clinical and staff recently recruited. However, there was scope to carry out risk assessments to decide whether long standing administration staff who took on chaperoning duties required a criminal records check. We did not see that this was carried out. After the inspection the practice confirmed they had carried out DBS checks for all staff.

Monitoring safety and responding to risk

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

We saw there was sufficient and up-to-date emergency equipment available for use by all trained and competent staff. Routine checks of this equipment were undertaken by a designated GP. Emergency medicines were available and were routinely audited to ensure all items were in date and fit for use.

We saw documented evidence of regular fire alarm system checks, smoke detector tests, emergency lighting tests as well as records of fire extinguisher tests and inspections. There was a detailed fire evacuation plan with records to confirm that regular fire drills were carried out. This ensured staff, patients and visitors were kept safe through the reduction of risk from fire.

Records showed that other essential risk assessments had been completed, such as health and safety, Display Screen Equipment (DSE) risk assessments and risk assessment for new and expectant mothers.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had a business continuity plan which covered a range of areas of potential risks relating to foreseeable emergencies such as adverse weather and loss of power. The plan demonstrated how these risks could be mitigated to reduce the impact on the delivery of the service. For example, the practice planned to continue working from two designated churches opposite the practice if their premises were not available. The business continuity plan detailed a cascade of actions and individuals to contact starting from the practice manager to other staff members.

Records we looked at showed that staff had received training in cardiopulmonary resuscitation (CPR). Emergency equipment was available including access to oxygen and an Automated External Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. Clinical staff we spoke with were aware of and had applied practice based on evidence. We saw example of how the practice used National Institute of Health and Care Excellence (NICE) guidance for management of patients with chronic obstructive pulmonary disease (COPD), conditions that affect the lungs and airways. NICE provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care.

Patients with a learning disability and mental health needs had annual reviews and care plans were put in place to ensure their needs were assessed and care was planned in accordance to best practice. Systems were also in place to review the care needs of those patients with complex needs.

Staff were aware of patients who were receiving end of life care because their details were displayed in the office behind the reception desk. There was a white board in the reception area used to communicate or highlight information such as arrangements to share information with out of hours services for when the practice was closed. Meetings were held with the palliative care teams to ensure the patients received coordinated care that respected their needs and wishes. When a patient on end of life care passed away, the practice always reviewed the quality of care that was provided. This helped to identify any learning that could be implemented to improve the care provided further to other patents.

Management, monitoring and improving outcomes for people

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF). 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 e.g. diabetes and implementing preventative measures. The results are published annually. The practice assigned different areas of QOF to different staff members depending on clinical lead roles. For example, the practice nurses reviewed chronic obstructive pulmonary disease (or COPD) QOF data. COPD is a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. QOF targets were reviewed in monthly practice meetings and we saw evidence of good QOF achievement.

The practice was undertaking an enhanced service to reduce unplanned admissions to hospital. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for the most vulnerable patients to best support them at home. The practice manager told us that they had identified 157 patients who could be best supported with a specific care plan. There were 13 care plans left to develop but this was due to patients declining. This allowed the practice to ensure that patients got the care they needed in a timely way and in the location that was appropriate for them.

Patients identified by GPs during the consultation as having mental health needs or those that had started treatment were followed up at appropriate intervals. Appointments were booked by the consulting GP at the time. Patients who did not attend for follow up appointments were identified on patient searches and the appropriate GPs were tasked to contact the patient if possible.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. We saw that the practice asked patients to complete minor surgery questionnaires 10 to15 days after their procedure so that service could be improved. We saw example evidence of a minor surgery audit carried out by one of the GP's looking at complications following procedures. This found that the complication rate was low and no improvements were identified.

Effective staffing

Practice staffing consisted of three GP partners and five salaried GPs. There was a team of three practice nurses, two healthcare assistants and administrative staff. We reviewed staff training records and saw that staff were mostly up to date with attending core training courses such

Good

Are services effective?

(for example, treatment is effective)

as annual basic life support. Some staff had not attended safeguarding adults training and were scheduled to attend. GPs were up to date with their yearly continuing professional development requirements and had been through revalidation while others were due their revalidation. Revalidation of GPs also took place every five years. The purpose of revalidation is to provide greater assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practice. Only when revalidation had been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.

We saw that annual appraisals had taken place to help develop and support staff. We saw that appraisals were used to identify developmental areas for staff and all of the staff who we spoke with felt supported in their role. All the GPs also had in-house appraisals carried out by partners and management in addition to their revalidation. This ensured any developmental areas were recognised and actioned.

The practice manager confirmed that most of the staff had worked at the practice for a number of years which provided stability within staff team and helped patients to receive continuity in their care. The practice had no staff vacancies at the time of our inspection and any shortfall in GPs, nursing or administrative staff as a result of sickness or leave was covered by internal staff. Although there was a stable staff team, some patients we spoke with told us that they found it difficult to get an appointment with the GP of their choice due to long waiting times.

Working with colleagues and other services

We saw timetables for meetings scheduled from January to December 2014. We saw that four different meetings were held monthly including practice meetings where representatives from each team including the practice manager attended. Clinical meetings held were attended by the GPs, nurses, and the CCG pharmacist. We saw evidence that the practice worked well with the pharmacist who supported them with their prescribing data so that patient care could be further improved. Monthly partners meetings and end of life care meetings were held where district nurse and Macmillan nurses attended. We saw that ad hoc multidisciplinary meetings were held for specific patients where clinical psychologists and social workers attended. We were told by a GP partner that the practice had the highest number of at risk children locally but regular formal meetings did not take place with other professionals such as health visitors and school nurses.

The practice also had a virtual ward with ad hoc meetings as and when required. The Virtual Ward is similar to a ward in a hospital environment in that it has a structure of both clinical and administrative staff that co-ordinates and provides direct care to patients. The main difference is that the actual wards do not physically exist to house all the patients in one location. The Virtual Ward aims to reduce hospital admissions by identifying patients who are at high risk of admission and supporting them more effectively in their own home.

There were systems in place to ensure results of tests and investigations received from hospitals and out of hours GP services were reviewed and actioned as clinically necessary. We saw a pro forma that was sent to out of hours services to communicate any management issues regarding complex or critical patients. There was a protocol and tasks on the computer system to manage incoming results for example from blood tests from hospitals. Sometimes GPs would use the text messaging system to communicate results to patients which also helped to take pressure off the phone lines. Other GPs we spoke with told us that they called patients regarding their test results which showed that there were inconsistencies in the way test results were dealt with. We spoke to the partners and the practice manager who told us that they would ensure a consistent approach.

Information sharing

We found that the practice worked with other service providers to meet people's needs and support patients with complex needs. The practice was in one of the most deprived areas within the locality and one of the GP partners told us that there were issues of safeguarding, domestic violence as well as high drug and alcohol related criminality within the area. However, given that the practice had the highest number of at risk children locally they did not hold regular meetings with other professionals such as health visitors and school nurses to address its own case load or discuss children at risk. Multidisciplinary meetings involving, for example social workers, community psychiatric nurses (CPN) and school nurses took place on an ad hoc basis.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005). The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themself. Staff files we looked at showed that staff had attended relevant training and staff we spoke with confirmed their understanding of capacity assessments and how these were an integral part of clinical practice.

We saw a consent policy in place and a toolkit to asses Gillick competency. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. We saw consent forms were in place for minor surgery. Where appropriate, carers were involved in the decision making process.

Almost all the patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. Patients felt they could make an informed decision. Patients with dementia, learning disability and mental health were given longer appointments to discuss their health needs.

Health promotion and prevention

The practice acted as a hub for other services including smoking cessation, substance misuse, hearing tests, counselling and a primary mental health care practitioner. The practice offered additional onsite clinics such as a dietician and long term conditions clinics such as diabetes, respiratory disease and hypertension was offered.

The practice had a wide range of health promotion leaflets and self-help guides in the surgery and on their website. We saw a comprehensive NHS health check template was in place. The practice did not routinely carry out new patient health checks instead all patients completed a registration form which included health promotion questionnaires. For example, questions related to alcohol consumption and smoking status were asked and after review by the administration team appropriate patients were invited for smoking cessation and alcohol intervention clinics.

The practice had a quarterly newsletter communicating health promotion and prevention activities and clinics. We saw that the 2014 autumn/winter newsletter made patients aware of the stoptober challenge and the benefits of stopping smoking. Stoptober is a national campaign that encourages people to stop smoking together on the 1 October for 28 days (and beyond). Alcohol awareness week was also advertised in the newsletter advising patients to make an appointment with their GP if they were concerned. Other health promotion campaigns were also advertised including world diabetes day, national stress awareness day as well as advising 'at risk' patents to get a flu jab.

The practice also had two well laid out health promotion notice boards informing patients of other services such as mental health and sexual health that was available to them. Various health promotion folders were also available in the main waiting area containing various leaflets.

The practice offered sexual health self-screening kits that were available away from the main reception area for patients to pick up. This was a CCG initiative but the practice had a slightly younger (15 to 30 year olds) population compared to the national average and was appropriate to the needs of the population.

The practice also offered periodic medical reviews for patients under the age of 75 who had not attended the surgery for the period of three years. Patients over the age of 75 were able to have annual medical reviews.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

On the day of the inspection we spoke with seven patients attending the practice. Before out inspection we spoke with three patents who were members of Patient Participation Group (PPG) about the practice. PPGs are a group of patients registered with a practice who work with the practice to improve services and the quality of care. In addition we looked at 21 patient comment cards received and feedback from the 2014 practice patient survey as well as other sources such as the national GP Patient Survey. We spoke with managers of three care homes to get their feedback. Our findings from comment cards, discussions with patients, representative groups and care homes were that patients were overall happy with the service and staff at the practice.

Patients we spoke with were generally satisfied with the care and treatment they had received. They said staff were friendly and caring. They felt involved during consultations as any results of tests were explained to them in a way they understood. We saw that the practice performed better in most areas than other local (CCG) practices in the national GP survey.

All the patients we spoke with told us that they had no concerns about issues related to confidentiality. This was also reflected in the comments cards we had received. The arrangement of the reception area meant that conversations could be overheard. However, there was a sign in the reception area informing patients that they can request a private area for discussions.

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. 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 consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be easily overheard.

Care planning and involvement in decisions about care and treatment

Patients told us doctors and nurses explained their care and they were involved in making decisions about their care.

We saw end of life planning took place. The GP held discussions with the patient and their family members as appropriate to discuss end of life care. Do not attempt resuscitation forms were completed and signed if this was the patients wish.

We found that clinical staff were aware of their legal and ethical responsibilities for gaining informed consent prior to treatment. Staff understood the purpose of the Mental Capacity Act (2005). The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themself. Staff files we looked at showed that staff had attended relevant training and staff we spoke with confirmed their understanding of capacity assessments and how these were an integral part of clinical practice.

Patient/carer support to cope emotionally with care and treatment

There was a bereavement process in place and we were told that a bereavement card was sent to families who had suffered bereavement as well as carers. Where appropriate, patients were signposted to other relevant services such as counselling or to mental health teams.

A depression assessment questionnaire was available on the practice website for patients to complete. This enabled GPs to be aware of a patient's emotional status, use the information to monitor the severity of depression and their response to a treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered a range of enhanced services (services over and above the essential/additional services normally provided to patients). For example, one enhanced service was the co-ordination and management of care of frail older people and other 'high-risk' patients to avoid unplanned admissions to hospital. We saw that the practice ran searches on their computer system for high risk patient groups and ensured appropriate reviews of their care had taken place.

The GPs provided primary care services to their patients living in local residential care homes. We received positive feedback from care home managers and told us they were overall satisfied with the care provided to the residents.

Staff turnover was stable which enabled good continuity of care and patients we spoke with were happy with staff at the practice. Many patients we spoke with told us that they found it difficult to get an appointment and the national GP patient survey reflected this. For example 44% of respondents described their experience of making an appointment as good which was worse than the local (CCG) average of 69%. However, those patients with complex needs, young children and elderly patients we spoke with told us that they were able to get an appointment easily. Home visits were also carried out for patients who were unable to attend the surgery. One lead GP told us that the patient demographics were such that the service was in high demand. They were trying various strategies to ensure demand was met such as reducing the DNA (did not attend) rates.

Staff told us that longer appointments were available for patients who needed them such as those with learning disabilities.

We saw that the practice offered patients the opportunity to feedback any issues to the management. There was a comments stand with appropriate forms that patients could fill in and post in the comments box. We saw that the practice displayed information about changes made to the service as a result of this feedback on the comments stand. This information was also recorded on the back of the forms so that patients could see that their feedback was making a difference. For example, one of the changes made was to open a results and enquiries line at 10am to free up lines for appointments at 8am.

New patients registering at the practice completed a registration form that gathered comprehensive details of their health and lifestyle choices. Appropriate patients were then offered consultation and other services such as referral to smoking cessation clinics.

Tackling inequity and promoting equality

The practice was located in temporary portacabins accommodation which were suitable and fit or purpose. They were accessible to patients who had difficulties with their mobility and hearing. The practice also had access to an interpreting service for patients whose first language was not English. A range of online services were available for appointments, repeat prescriptions and health promotion and screening information.

The practice made use of other services available in the area for vulnerable patients such as the community drug and alcohol team and the team for people with a learning disability. The practice invited all patients on their learning disabilities register to the surgery for an annual health check and for flu vaccinations if appropriate. Additionally, the practice website provided links to information relevant to male and female health concerns.

Various systems were in place to aid working patients to access the service. This included extended opening hours and telephone triage. Some GPs sent text reminders to patients about test results while others telephoned patients instead.

We saw that there was a wide range of information in the waiting area signposting patients to support services that were available to them.

Patients had access to a variety of health information on display in the waiting area of the practice and also on the practice website. Patients were informed that they could request large print leaflets in they needed. The practice website allowed patients to translate the content in various languages to enable patients to make informed choices. The practice also offered a translation service to patients who did not have English as a first language, although we were told that it was not used often.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had extended the surgery opening times in the evening three days a week as part of a local enhanced service which meant patients who were working or not able to attend during normal practice hours were able to see a GP.

We saw that the practice performed worse than local practices in regards to access to appointments. Some of the patients we spoke with also confirmed that they found it difficult to get appointments or get through on the telephone. One of the GP partners told us that there was a high demand for services and including those requesting same day appointments. The practice ensured those patients with pre-existing conditions and emergency patients were seen as a priority. We spoke with some patients with long term and complex medical issues and they confirmed that they were able to get appointments easily. One patient we spoke with told us that, given their health need, they had no trouble getting an appointment.

Patients were able to book and order repeat prescriptions online from their own homes. This was useful for working age patients as well as those who had difficulty with their mobility.

The practice website could be read in many other languages through Google translate.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external service contracted by the CCG. Details of out of hours provider was on the practice website as well as in the surgery.

The practice also looked after patients in local care homes. Patients living in care homes could attend the practice, request telephone consultation or have home visits. The GPs also undertook ward rounds in care homes on a regular basis which allowed for better support to patients and reduced impact on the appointment system. Feedback from the managers of the care homes was positive.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person in the policy to handle all complaints at the practice. There were records of many complaints going back over two years. There were summary pages with individual complaints so that trends could be identified.

Are services well-led?

Good

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

Our findings

Vision and strategy

There was a clear leadership structure and staff felt supported by management. Photographs of key staff were displayed in the practice waiting area introducing their roles and any other responsibilities. Staff we spoke with were aware of their roles and of the roles of other staff members when their duties overlapped. The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk. For example, we saw evidence of the practice flu action plan for the past year and the current year to ensure all patients eligible for flu jabs were identified and contacted.

Governance arrangements

We saw pictures of staff members in the patient waiting area listing their roles and responsibilities. Staff told us that there was visible and strong leadership. The management structure included the practice manager and a deputy practice manager who was responsible for IT and health and safety. There were administrative supervisors in place and nurses and GPs had lead roles and responsibilities that supported the governance framework at the practice.

All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. The practices vision and values were understood by staff that we spoke with and they told us that these were discussed during appraisals.

We saw that the practice had key performance indicators (KPIs) which were used to monitor their performance.

Leadership, openness and transparency

We saw evidence of staff appraisals that were regularly undertaken. The practices vision and values were understood by staff that we spoke with and they told us that these were discussed during appraisals and used for target setting.

Staff members we spoke with felt supported in their roles and were able to speak with the practice manager if they had any concerns. They told us that opportunities for progression were discussed and actioned where appropriate.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had responded to feedback on service delivery from the Patient Participation Group as well as other patients through surveys and complaints. We saw that changes had been made to improve service as a result of feedback.

We spoke to three members of the patient participation group (PPG) before our inspection and they told us that the practice was very good at involving them. PPGs allow the practice to work with patient groups to improve the service being offered. PPG members told us that their feedback was used to introduce new facilities such as areas for push chairs as there were many young patients registered with the surgery. The also told us that they worked with the practice to reduce the number of patents that did not attend their appointments (DNA) and asked for the DNA rate to be communicated to patients. We saw DNA rates were being communicated to patients in the practice newsletter and waiting area. The practice sent text message reminders to patients before their appointment. A PPG member told us that they had asked for an additional question to be included in the text message asking patients if they still wanted the appointment in a bid to reduce DNA numbers.

The practice had gathered feedback from patients through annual patient surveys. We looked at patient surveys carried out in September 2013. We saw that an action plan with a summary had been developed from the findings of the practice surveys and they were discussed with the Patient Participation Group (PPG). Where appropriate actions were assigned to different staff members based on their roles and responsibilities.

For example, we saw that there was a 75% satisfaction rate with reception staff which was a marginal decrease from the previous (2012) practice survey. The practice action plan stated that further refresher training was to be offered to staff so that they could offer a quality service to patients. Staff members we spoke with confirmed that they had received the training. We also noted that the action plan stated that one of its key performance indicators for 2014 was providing quality care and the training was also linked to this performance indicator. We saw that the responsible person for ensuring implementation of action plan was the practice manager.

Are services well-led?

Good

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

In another example, we saw that there was a slight decrease in the satisfaction rate for opening hours compared to the survey carried out in 2012. We saw that appropriate analysis was carried out for the reasons and appropriate action plans were put in place. This included better advertisement of its opening hours as well as its three extended evening opening hours on the practice leaflet, website and on the display screens in the waiting area. We saw evidence that this was done.

Before our inspection we noted in the GP national survey that patients were not satisfied with the access rate to the practice. We saw that this had been picked up by the practices own survey from September 2013 where 74% patients said they could get an appointment within three days with any GP. This was even lower at 39% if a patient wanted to see a GP of their choice. The surveys were analysed and some of the reasons discussed were increased patient demand, increased chronic disease prevalence in the area and high rates of failure to attend appointments by the practice (DNA). We saw evidence of the response by the practice which was to run education campaign in the waiting area advising patients of the alternatives to booking an appointment with a GP. We also saw that the practice newsletter informed patients of the number of missed appointments for October 2014 were 347 equalling 4000 minutes of wasted appointment time.

We saw evidence that the practice collected and acted on patients comments. Actions taken were communicated to patients. This showed the practice listened and acknowledged patients comments.

Management lead through learning and improvement

The practice had a system in place for completing clinical audit cycles. The practice had carried out both administrative and clinical audits. Administrative audits included appointment audits. The practice was aware of unmet demand and wanted to check if they were offering similar number of appointments per patient per year to other services within the Solihull. The outcome was that the practice was offering average appointments for North Solihull and higher than South Solihull. Other administration audits included home visits undertaken by GPs. Home visits take up administration time that GPs would otherwise use to process prescriptions and referral letters amongst other duties. The aim of this audit was to check all GPs were getting equal number of home visits. The practice had not yet completed this audit to determine what the outcome was.

Other audits included checking medical records for inaccuracies, out of date data and missing data. Findings were shared with staff and any follow up action was assigned to an appropriate staff lead. Clinical audits included many medication audits with input from the CCG pharmacist who attended once weekly. We saw an example of a re-audit of sip feed prescribing and saw that improvements were recognised and further learning identified. We spoke with the CCG pharmacist who told us that the practice acted on the findings of the medicine audits and followed up any actions identified.