Dr M Cuthbert and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr M Cuthbert and Partners on 25 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw some areas of outstanding practice including:

- The practice held themed open days for patients to provide further information, advice and support about certain health matters. The themes included a chronic obstructive airways (COPD) awareness open day which provided the opportunity to meet the new nurse practitioner who specialised in COPD. Know your blood pressure, dying matters and resuscitation for

Summary of findings

babies. A carers event was also held and a heart rhythm day. The events were planned for the year and advertised via leaflets, posters and word of mouth in the practice. Staff told us they were well attended by patients.

- The practice employed a community matron to supported patients' living in residential and nursing homes as well as their own homes. This provided closer monitoring of patients' in their home and ensured they had a care plan in place to deliver appropriate care and treatment. This reduced the number of days patients with long term conditions spent in hospital following an emergency admission. The practice was 4% lower than the CCG average.
- Patients had access to an area on their electronic patient record which provided 'self-care' support. It allowed patients, with the continued support of the GP, to make decisions using data from their electronic health record to change their lifestyle and improve their overall health.

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

Importantly the provider should:

- Review arrangements for the storage and tracking of electronic prescriptions within the practice to meet national guidance.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings showed systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence guidelines (NICE) and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice employed a community matron who assisted the GPs reviewing patients' in their own homes. The practice had identified and diagnosed 86.2% of expected cases of dementia compared to the local average of 70.4% and national average of 59%. The practice used a system which allowed GPs to send patient referrals electronically and share electronic patient records with specialists through the patient record system.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings. The practice held themed open days, such as know your own blood pressure. They also facilitated a knit together and stroke survivors support groups for patients.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day. The practice had very positive national GP patient survey results. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The PPG was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were above average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. People over the age of 75 had a named GP who was supported by a buddy GP to promote continuity of care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice employed a community matron who would see patients in their own home. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients had access to an area on their electronic patient record which provided 'self-care' support. It allowed patients, with the continued support of the GP, to make decisions using data from their electronic health record to change their lifestyle and improve their overall health.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety four percent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During our visit we spoke with seven patients and reviewed 21 completed CQC comment cards. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive referring to the difficulty booking an appointment with the same GP and the practice no longer sent out reminders for health checks. We were told by staff reminders were still sent to patients by way of a note on their repeat prescription. Staff acknowledged if the patient received their repeat prescription from the pharmacy they may not automatically see this as a reminder to make an appointment. Patients we spoke with told us their health issues were discussed with them and they were involved in decision making about the care and treatment they received from practice staff. Three patients we spoke with told us they had long term conditions and had an agreed care plan in place and they said they had been involved in making decisions and were informed when their reviews were due.

The results of the most recent (January 2015) national GP patient survey indicated of the 111 patients (36% response rate) who had responded showed patients were very satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 97% of practice respondents saying the GP was good at listening to them compared to the CCG average of 87% and 97% saying the GP gave them enough time compared to the CCG average of 84%. Eighty two percent of respondents reported the nurse was good at listening to them compared to the CCG average of 79% and 82% saying the GP gave them enough time compared to the CCG average of 80%.

The practice was performing better than the average for all practices in the Clinical Commissioning Group (CCG) in the following areas. Ninety six percent of respondents would recommend this surgery to someone new to the area compared to 75% for the CCG average. Respondents rated the practice 16% higher than the CCG average for getting through to the surgery by phone.

Areas in the national GP survey where the practice was rated lower than the CCG average were

38% of respondents with a preferred GP usually got to see or speak to that GP compared to 47% locally.

Areas for improvement

Action the service SHOULD take to improve

- Review arrangements for the storage and tracking of electronic prescriptions to meet national guidance.

Outstanding practice

We saw some areas of outstanding practice including:

- The practice held themed open days for patients to provide further information, advice and support about certain health matters. The themes included a chronic obstructive airways (COPD) awareness open day which provided the opportunity to meet the new nurse practitioner who specialised in COPD. Know your blood pressure, dying matters and resuscitation for babies. A carers event was also held and a heart rhythm day. The events were planned for the year and advertised via leaflets, posters and word of mouth in the practice. Staff told us they were well attended by patients.
- The practice employed a community matron to supported patients' living in residential and nursing homes as well as their own homes. This provided

closer monitoring of patients' in their home and ensured they had a care plan in place to deliver appropriate care and treatment. This reduced the number of days patients with long term conditions spent in hospital following an emergency admission. The practice was 4% lower than the CCG average.

- Patients had access to an area on their electronic patient record which provided 'self-care' support. It allowed patients, with the continued support of the GP, to make decisions using data from their electronic health record to change their lifestyle and improve their overall health.

Dr M Cuthbert and Partners

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 second inspector, a GP specialist advisor and practice manager specialist advisor.

Background to Dr M Cuthbert and Partners

Dr M Cuthbert and Partners practice, or Westcliffe Medical Practice as it is known locally, is located in the village of Shipley on the outskirts of Bradford. The practice provides personal medical care services for approximately 11,106 patients under the terms of the locally agreed NHS Primary Medical Services contract. The practice catchment area includes Moorhead, Saltaire, Baildon and Baildon Green. The practice is classed as being within the group of the fourth more deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Bradford and District Commissioning Group (CCG) area.

The Partners of Dr Cuthbert and Partners practice hold other contracts with NHS England for the provision of personal medical services. This group of practices is known as the 'Westcliffe group'.

In addition, the Westcliffe Group of practices work closely with Shipley Medical Centre, Haigh Hall Medical Centre and Sunnybank Medical Practice as part of a confederation to further develop patient care services.

Four of the GP partners, three female and one male, hold regular weekly clinical sessions at the practice. They are supported by three male and one female salaried GPs and up to three qualified doctors for a six to twelve month clinical placement as part of the GP training scheme. In addition the practice has six advanced nurse practitioners, three practice nurses, one assistant practitioner, two healthcare assistants an echo cardiologist, a pharmacist and a team of administrative and management staff.

The practice is open from 7.30am until 7.00pm Monday, Tuesday and Wednesday and 8.30am to 7pm on Thursday and Friday. Between 8am and 8.30am on Thursday and Friday the practice reception is open to answer telephone calls and the on call GP is available to speak to patients over the telephone. It is open on Saturdays from 8.30am until 2pm. GP appointments are available during the opening times and lunch period twice a week. Minor surgery, diabetes, asthma, family planning, antenatal and mother and baby clinics are run each week. Out of hours care is provided by Local Care Direct and could be accessed via dialling the surgery telephone number or NHS 111 service.

Dr Cuthbert and Partners is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services surgical procedures and the treatment of disease, disorder or injury from Westcliffe Medical Centre, Westcliffe Road, Shipley, Bradford, BD18 3EE.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the

legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed information we held about the practice and asked Bradford District CCG and NHS England to share what they knew. We carried out an announced visit on 25 February 2015. During our visit we spoke with four GPs, a GP Registrar, the managing partner, the head of governance, four nurses and three members of the administrative team. We also spoke with seven patients who used the service and reviewed 21 comment cards where patients 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff told us they were encouraged to report incidents via the practices electronic reporting system.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Safe track record

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events which had occurred during the last three years were made available to us and we were able to review these. "Significant events" was a standing item on the weekly practice meeting agenda. There was evidence the staff had learned from these and the findings were shared with the practice team. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings. They told us they felt encouraged to do so.

Learning and improvement from safety incidents

We were shown the system used to manage and monitor incidents. Staff completed an incident form on the electronic record system which was assigned to their line manager to investigate. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we were shown an incident where there was a delay in diagnosing a patient's symptoms. The incident record contained the investigations undertaken and reported how to avoid the situation happening again. We saw evidence the findings were discussed at the weekly practice meeting. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by a practice nurse. We were told alerts were initially risk assessed and then cascaded to the relevant practice staff. Staff we spoke with were able to give examples of recent alerts. They also told us alerts were discussed at the weekly internal multidisciplinary meetings. We saw the notes of practice meetings were available to all staff via the electronic system. Staff told us they would read the notes of the meeting on a weekly basis if they did not attend.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level 3 in safeguarding and could demonstrate they had the necessary skills to enable them to fulfil this role. All staff we spoke with were aware of the leads and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans. Records included the contact details of all close family members and significant others the child had contact with. We were told how the practice identified and followed up children, young people and families living in disadvantaged circumstances. This included looked after children, children of substance abusing parents, young carers, and those with a high number of accident and emergency attendances.

GPs were appropriately using the required codes on the patient record system to ensure risks to children and young people who were looked after or on child protection plans

were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults. Staff told us they liaised with partner agencies such as the police and social services. Practice staff told us they attended safeguarding case conferences and serious case reviews when necessary. If they were unable to attend they would receive the report following the meeting. Nursing staff told us they would actively follow up those children and adults who persistently failed to attend appointments. They would also liaise with other agencies such as health visitors and school nurses, for children, when appropriate.

The practice held monthly multidisciplinary meetings which the health visitor, community paediatrician, community matron, palliative care team, pharmacist, physiotherapy and occupational therapists attended. Other health and social care staff attendance could be requested if needed.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks 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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We were told about two reported incidents where the policy had been followed due to power failure to the fridges. The incident record recorded the investigation, actions taken and subsequent change to practice.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Staff did tell us occasionally they stored specimens in sealed bags in the vaccine fridge. This occurred after the last specimen collection time of the day. We did not observe any specimens in the fridge on the day of our visit.

We were told all prescribing data was monitored as part of the individual prescriber's performance review. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. Prescribing activity data tables were produced so prescribing staff could monitor their activity against their colleagues. One prescriber told us they had used this information to seek support from another member of the team when prescribing a specific group of medicines. They told us this had aligned their prescribing activity.

The advanced nurse practitioners' were qualified as independent prescribers. They received regular supervision and support in their roles as well as updates in the specific clinical areas of expertise they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We observed blank prescription forms for use in printers were stored in a locked cupboard which was accessible to all staff. They were not tracked through the practice. We reported this immediately to the managing partner on the day of our inspection. We were told the storage and tracking of prescriptions would be immediately reviewed. Hand written prescriptions were stored and handled in accordance with national guidance.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out annual infection control audits for the last three years. We saw on

the action log any improvements identified were completed on time. We were shown minutes of multidisciplinary practice meetings which recorded actions following the audits were they had been discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. Reception staff told us the procedure for accepting specimens from patients at the reception desk. They showed us the personal protective equipment available in reception. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water).We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for all members of staff, including nursing and administrative staff, to cover each other's annual leave. Medical and nursing staff operated a 'buddy' system. The staff member would pair up with a peer who then covered for them when they were not at work. Staff told us the system ensured any follow up treatment for patients would be actioned in their absence.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The managing partner showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw risks on the log were discussed at GP partners' monthly meetings and within team meetings. For example, the head of corporate governance had shared the recent findings from the fire assessment with the team.

There were processes in place for identifying patients presenting with an urgent need on the telephone. Reception staff would pass the patient details to the GP on call as 'urgent' who would then contact the patient as a priority. The patient would be offered a same day appointment if needed.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed 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 it was checked regularly. Staff told us about a recent medical emergency concerning a patient and described the actions taken. We were told it was reported as a significant event and staff had the opportunity to de-brief afterwards.

Emergency medicines were available in a secure area of the practice and all staff could tell us the location. These included adrenaline (which can be used to treat anaphylaxis); hydrocortisone (for treating asthma or recurrent anaphylaxis). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan 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 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 for the power companies.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this where the practice had to relocate to a neighbouring practice due to power failure. The actions were documented to manage this if it should happen again.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of weekly practice meetings where new guidelines were disseminated. The implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses, staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the advanced nurse practitioners supported this work. This allowed the practice to focus on specific conditions. Some GPs held specialist interests and led on these areas within the practice and externally. They offered specialist appointments for patients at the practice and from other practices within the local area. For example a patient who required a dermatology referral could be referred to a GP with a special interest in dermatology. A patient we spoke with told us they had been referred to a specialist GP and received treatment which they had previously received in hospital. They commented how quickly they were seen and how convenient it was to be treated nearer home. Referral rates to secondary care were 4% lower than the CCG average and 16% lower than the national average. We were told this was because patients with certain conditions could be referred to GPs with specialist interest within the practice.

All GPs we spoke with used national standards for the referral of musculoskeletal conditions but could include patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of patient conditions.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within three days of discharge. The practice employed a community matron who assisted the GPs reviewing these patients. We were told the purpose of the review was to check the discharge was safe and follow up care was in place for the patient. The community matron's work supported patients' living in residential and nursing homes as well as their own homes. The GP partner told us this provided closer monitoring of patients' in their home as it ensured they had a care plan in place to deliver appropriate care and treatment. In turn this reduced the number of number of days patients with long term conditions spent in hospital following an emergency admission. The practice was 4% lower than the CCG average. The community matron's work also reduced the number of home visits for GPs which increased the number of GP appointments available to patients in the surgery.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the managing partner and GP partners to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us 19 clinical audits had been undertaken in the last two years. Eleven of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

Good

Are services effective?

(for example, treatment is effective)

We were shown the details of an audit of patients who had tests for dementia. The audit looked at the baseline assessment then the use of the data quality toolkit to improve accuracy of diagnosis. The outcome was a more accurate diagnosis of dementia was achieved using the toolkit which enabled the most appropriate support for patients and their families. The practice had identified and diagnosed 86.2% of expected cases of dementia compared to the local average of 70.4% and national average of 59%. Other examples included an audit to review the timing of blood tests for patients receiving a disease modifying medication to ensure safe prescribing. The second cycle of the audit demonstrated 97% of patients were having timely blood tests performed in line with National Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from 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 and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and aligned their practice to the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Staff at the practice used QOF to measure its performance against national screening programmes to monitor outcomes for patients. Dr M Cuthbert and Partners achieved 97.7% of the QOF score for 2013-14. This was three percent above the local CCG average. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, 88% of patients with diabetes had an annual medication review and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). Ninety six percent of diabetic patients had a retinal screening test which was held in the practice. Ninety four percent of patients with a long term mental health condition attended for an annual review which was higher than the CCG average of 86%.

The practice had developed care pathways within the electronic patient record system to promote best practice in patient care. Staff told us how the pathways acted as an aide-memoire for all clinicians providing the patient with a consistent approach to their care. Staff told us the weekly practice meeting was used as a forum to discuss patients with complex medical, social problems and end of life care to promote patient centred care.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. All staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation all clinical staff (GPs and advanced nurse practitioners) should undertake at least one audit a year which was monitored through the performance management process.

There was a protocol for repeat prescribing which was in line with national guidance. Staff complied with this by regularly checking patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The electronic patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm after receiving an alert the GPs would review the use of the medicine in question. They told us where they continued to prescribe it they would outline the reason why they decided this was necessary. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes were comparable to other services in the area. For example the practices anti-bacterial prescribing was comparable to the CCG average.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas in sexual and reproductive medicine, children's health and obstetrics. The GP with specialist interests all were trained and kept up to date with their areas of speciality. For example dermatology, musculoskeletal conditions and medicine. 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 practise and remain on the performers list with NHS England).

We were shown support programmes for new staff. All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example a GP was undertaking a diploma in dermatology. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. Student nurse placements were also facilitated at the practice. Again we received positive feedback from the students.

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

We were told a policy for managing performance was being developed. The managing partner told us managers had not needed a staff performance policy as there had been no recent performance issues with staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The practice told us about the buddy system whereby if a GP was not at work their buddy would review the results. 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for new enhanced services and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook a monthly review of follow-ups to ensure inappropriate follow-ups were documented and no follow-ups were missed.

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

Good

Are services effective?

(for example, treatment is effective)

The practice has also signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice 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. We saw evidence audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

We were told about the electronic system which allowed GPs to send patient referrals to other specialists and hospital consultants electronically via the patient record system. The specialist could then view clinical details, recent medication and previous communication from other clinicians. A decision could then be made by the specialist as to whether the patient should be referred to a specialist clinic or sent for more tests. Notes could then be added directly to the record to be viewed by any clinician caring for the patient.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed quarterly (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Practice staff kept records and showed us 83% of dementia care plans had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

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

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. They were offered an annual physical health check. Practice records showed 50% had received a check up in the last 12 months. The practice had also identified the smoking status of 96% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 31%, which was above average compared to neighbouring

Good

Are services effective?

(for example, treatment is effective)

practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80%, which was slightly better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

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

We were told patients with long term conditions had access to an area on their electronic patient record which provided 'self-care' support. It allowed those patients, with the continued support of the GP, to make decisions using data from their electronic health record to change their lifestyle and improve their overall health. Patients were able to set goals in the system based on the self-care information available which was shared with the GP. Staff told us this was popular with patients with long term conditions who were keen to improve their lifestyles. A patient described how this system helped them adjust their lifestyle choices to have a positive impact on their health.

The practice kept a register of patients who were identified as being at high risk of hospital admission and end of life care plans. The plans were shared with other care providers via the electronic patient record system. Each patient had a named GP and a clinical co-ordinator who could be a member of practice or community staff.

We were told the pharmacist reviewed patients who took many medicines by completing structured annual medication reviews. If the patient was not able to get to the practice for the review they would be visited by the pharmacist at home. All patients over the age of 75 had a named GP who was supported by a buddy GP to promote continuity of care.

Practice staff showed us the resources available to patients experiencing poor mental health. This included voluntary sector agencies to promote independent living and patients could be referred to primary care based talking therapies. Annual health reviews were offered to patients with severe mental health issues and the uptake was 94% which was above the average of 86% for the local area. Patients were offered flexible appointment times avoiding booking appointments at busy times for people who may find this stressful.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey in January 2015. The evidence showed patients were very satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 97% of practice respondents saying the GP was good at listening to them compared to the CCG average of 87% and 97% saying the GP gave them enough time compared to the CCG average of 84%. Eighty two percent of respondents reported the nurse was good at listening to them compared to the CCG average of 79% and 82% saying the GP gave them enough time compared to the CCG average of 80%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive referring to the difficulty booking an appointment with the same GP and the practice no longer sent out reminders for health checks. We were told by staff reminders were still sent to patients by way of a note on their repeat prescription. Staff acknowledged if the patient received their repeat prescription from their pharmacy they may not automatically see this as a reminder to make an appointment.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw staff were careful to follow the practice's confidentiality policy when talking to patients' so confidential information was kept private. The practice switchboard was located behind the reception desk with a half wall which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with their manager or the managing partner. The managing partner told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice very well in these areas. For example, data from the national GP patient survey showed 86% of practice respondents said the GP involved them in care decisions compared to the CCG average of 74%. Ninety two percent reported the GP was good at explaining treatment and results compared to the CCG average of 80%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. A member of staff told us how they had translated a hospital referral letter for a patient who enabled the patient to understand why they were being referred and the location and time of the appointment.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to were positive about the emotional support provided by the practice and rated it well in this area. For example, two patients told us about the support services offered to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with this feedback.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

The practice also facilitated a knit together support group and stroke survivors support group. A patient told us how valuable she found the groups and to be able to meet other patients with similar conditions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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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 practices aims and objectives were part of the practice statement of purpose. These values were clearly displayed in the waiting areas. This included providing clinical quality and to improve patient care. We spoke with 14 members of staff and they all knew and understood the aims and objectives and could tell us what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner was the lead for safeguarding. They were supported by buddies who staff told us they would access in the leads absence. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The corporate governance manager showed us the risk log, which addressed a wide range of potential issues. For example the practice had identified the risk associated to the organisation growth and how this could be mitigated to ensure existing staff felt supported. We saw the risk log was regularly discussed at weekly meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held weekly meetings. We looked at minutes from the last three meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings.

Performance data for clinical and medical staff was produced and enabled them to review their performance against their peers. We were told how prescribers found this useful particularly around improving prescribing trends.

The human resource manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example staff appraisal and the induction policy were in place to support staff. We were shown the electronic staff handbook which was available to all staff. It included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through a survey of 245 patients about access over a four week period. We looked at the results of the survey and it was identified to review the auto attendant on the telephone to improve telephone access for appointment booking. We saw as a result of this the practice created a focus group to address the issues.

The practice had an active PPG which had steadily increased in size and was held jointly with another practice in the group. The PPG included representatives from various population groups; including those over 75 and with longer term conditions. The PPG had supported the practice with the annual patient surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through a staff survey, practice learning days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One

Are services well-led?

Good

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

member of staff told us they had asked for specific training in administrative functions and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had regular staff training sessions where guest speakers and trainers attended.

The practice was a GP training practice and offered student nurse placements. The trainees and students we spoke to told us they were well supported at the practice. Staff told us they had received feedback from the local GP training scheme stating they were a caring and supportive practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.