Castlecroft Medical Practice

Quality Report

Castlecroft Avenue
Castlecroft
Wolverhampton
West Midlands
WV3 8JN
Tel: 01902 761629
Website: Castlecroftmedicalpractice.co.uk

Date of inspection visit: 12 December 2014
Date of publication: 11/06/2015

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 a comprehensive inspection at Castlecroft Medical Practice on 12 December 2014. The practice is registered with the Care Quality Commission to provide primary care services to its local population. This is the report of the findings from our inspection.

We have rated each section of our findings for each key area. The practice provided an effective, caring, responsive and well led service for the six population groups it served but required improvement to provide a safe service. The overall rating was good and this was because the practice staff consistently strived to provide a good standard of care for patients.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Infection prevention and control systems were well managed and staff had received appropriate training. Lead roles had been assigned to manage infection control and staff were aware of who held the lead role.
- The practice was proactive in measuring and monitoring risks to patients and services provided. Risks identified were discussed at practice meetings and evidence was available to demonstrate that necessary action had been taken where risks were identified.
- Systems were in place to review the care needs of those patients with complex health needs or those in vulnerable circumstances. Patient care co-ordinators at the practice made regular contact with these patients to help ensure that they attended routine health checks and immunisations.
- Patients said that the GPs listened to what they had to say and treated them with compassion, dignity and respect. Patients told us that they were involved in their care and decisions about their treatment.
- Patients reported good access to the service; those patients who required an urgent appointment were

Summary of findings

given an appointment on the same day that they telephoned. Those patients who were hard of hearing were able to email requests for urgent appointments. Patients were able to book and cancel appointments on-line, by telephone or by visiting the practice.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice manager, business manager and GP partners were responsible for monitoring and review of systems and practices with the aim of continuous improvement. These management staff were aware of areas that required improvement and had identified action to be taken to address these issues.
- There was an open culture within the practice and staff were actively encouraged to raise concerns and suggestions for improvement. The practice philosophy and practice charter were available for patients. This document included information regarding access to the service, waiting times and complaints. The practice had a clear vision to deliver high quality care and good outcomes for patients. Staff demonstrated a person-centred approach and through discussions it was obvious that delivering high quality care to meet patient's needs was of paramount importance.
- There was an active Patient Participation Group (PPG) who met on a regular basis. The PPG reported an excellent relationship with the practice and confirmed that the practice listened and acted upon suggestions made by them. Learning events requested by the PPG, which related to the needs of the practice population had been organised. One PPG member had been involved in the recent employment of the Business manager.

We saw the following areas of outstanding practice:

The practice provided a good range of nurse led clinics which supported the role of the GP. Patients with long term conditions were allocated to patient care advisors. Patient care advisors were responsible for ensuring that a robust system of patient calling for long term conditions was in place. Each member of the team had their own list of patients. Patients would be contacted by telephone and then letter. A system of recording contacts and attempted contacts with patients had been implemented.

The practice encouraged membership of their Patient Participation Group (PPG) through posters displayed in the waiting room and information on their website. The PPG met on a regular basis and received support with meetings from practice staff who also attended these meetings. Educational events were organised by practice staff for the PPG and recent events had included pain management, stroke and resuscitation training. Guest speakers had been invited to talk about the local alcohol services, a urology talk, eating disorders and dementia. Some of the guest speakers had been suggested by the PPG and some by the GP according to the needs of the practice population. The PPG confirmed that they were informed and involved in any changes at the practice. One of the PPG members had been involved in the recent employment of the Business Manager. PPG members had been invited to meet candidates prior to their interview and to give feedback to the practice manager and lead GP.

However, there were also areas where the practice should make improvements.

- Ensure that recruitment processes are followed so that information required under current legislation is obtained prior to employment.
- Ensure the appraisal system for nursing staff includes personal development plans.

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 a safe service. Staff understand and fulfil their responsibilities to raise concerns, and report incidents and near misses. Lessons are learned and communicated widely to support improvement. Information about safety is recorded, monitored, appropriately reviewed and addressed. Risks to patients are assessed and well managed. There are enough staff to keep people safe. However, at the time of our inspection the practice had not followed their recruitment policy for one member of staff and had not undertaken criminal records bureau checks on all relevant staff.

Are services effective?

Good

The practice is rated as good for providing an effective service. Data shows that patient outcomes are at or above average for the locality. National Institute for Health and Care Excellence (NICE guidance is referenced and used routinely. Patient's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for the majority of staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing a caring service. Data shows that patients rate the practice higher than others for several aspects of care. Patients said they are treated with compassion, dignity and respect and they are involved in care and treatment decisions. Accessible information is provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing a responsive service. The practice reviews the needs of their local population and engages with their Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients report good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice has good facilities and is well equipped to treat patients and meet their needs.

Summary of findings

There is an accessible complaints system with evidence demonstrating that the practice responds quickly to issues raised. There is evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice has a clear vision which has quality and safety as its top priority. The strategy to deliver this vision has been produced with stakeholders and is regularly reviewed and discussed with staff. High standards are promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements are proactively reviewed and take account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and they have a very active patient participation group (PPG).

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 the practice had good outcomes for conditions commonly found amongst older people The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. Care plans had been developed for the patients at the practice with more complex needs with the aim of avoiding unplanned hospital admissions. All patients had access to a named GP with those over the age of 75 being specifically informed of who this is. Extended opening hours were provided two nights per week to allow carers and relatives of older patients to gain access to the service. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Home visits were undertaken every day by all GPs on duty and the nursing team provided a home visit service on most days to support the service provided by the local district nursing service and to provide long term condition management and reviews.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. All patients with long term conditions were offered reviews appropriate to their condition and personal needs. The reviews were undertaken by both GPs and nurses with the recall system managed by the patient care advisor team to ensure a patient centred robust approach to calling patients for follow ups and reviews. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients who were housebound or living in residential homes were visited by either a nurse or GP dependent upon their needs. All these patients had a named GP and structured annual reviews 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. The practice was working closely with a diabetes consultant to improve overall outcomes for diabetes patients whilst focussing on those with complex or uncontrolled symptoms.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice provided clinics for all childhood immunisations and post natal mother and baby checks. There was an additional GP led child health clinic every Tuesday afternoon and the local health visiting team visited the practice for mother and child drop in once a week. Community midwives held antenatal sessions twice a week. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. For example, MMR vaccination rates for five year old children were 92.5% compared to an average of 84.7% in the local CCG area and PCV Booster rates for the same age group were 96.3% compared to an average locally of 92.4%. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. All practice staff receive regular safeguarding training appropriate to their role.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The 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. Patients could book appointments and order repeat medication on-line as well as being able to submit comments and change personal details via the practice website. The practice was proactive in offering a full range of health promotion and screening which reflected the needs for this age group. The practice offered appointments until 8.00pm twice a week for both GP and nurse. A number of patient group meetings were also scheduled in the evening to allow this population group to attend.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out a comprehensive annual health check; part GP, part nurse for people

with learning disabilities, to ensure their health needs were met and all of these patients had received a follow-up. Appointments were available for a variety of times to accommodate the booking needs of patients who may need help from relatives or carers. The practice offered longer appointments for people with learning disabilities.

The practice sign-posted vulnerable patients to various support groups and voluntary or community sector 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 and out of hours.

There were no barriers to access for any patients and a full interpreting service was available including British Sign Language (BSL).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All patients with mental health problems were offered an annual review including general healthy lifestyle advice from the nurses. Most of this patient group had a personalised care plan according to their needs. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and community and voluntary sector organisations including the local Healthy Minds Service. Patients were also signposted to a counsellor who was based at the practice for one day every two weeks and the practice had good links to the wider mental health service network provided by the Black Country Partnership.

Summary of findings

What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received eight completed comment cards and on the day of our inspection we spoke with five patients. All of the comments received were positive. Patients commented that staff were caring, the GP was helpful and the service was efficient. Patients spoken with on the day of inspection said that they received a good quality of service provided by helpful, efficient and caring staff.

The latest National GP Patient Survey completed in 2013 showed patients were satisfied with the services the practice offered. The results were mainly in line with other GP practices nationally, and in some areas better. The practice were rated as among the best regarding the proportion of patients who would recommend their GP surgery (88%) and the proportion of respondents who described the overall experience of their GP surgery as good or very good (92.8%). Patients also were satisfied with the opening hours (78%) and 86.2% of patients said that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment.

These results were based on 103 surveys that were returned from a total of 253 sent out; a response rate of 41%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that recruitment processes are followed so that information required under current legislation is obtained prior to employment.
- Ensure the appraisal system for nursing staff includes personal development plans.

Outstanding practice

The practice provided a good range of nurse led clinics which supported the role of the GP. Patients with long term conditions were allocated to patient care advisors. Patient care advisors were responsible for ensuring that a robust system of patient calling for long term conditions was in place. Each member of the team had their own list of patients. Patients would be contacted by telephone and then letter. A system of recording contacts and attempted contacts with patients had been implemented.

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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.

Background to Castlecroft Medical Practice

Castlecroft Medical Practice was based in the Wolverhampton Clinical Commissioning Group (CCG) The practice provided primary medical services to approximately 12,100 patients in the local community. The population covered was predominantly white British.

The lead GP at the Castlecroft Medical Practice was present during our inspection. There were four male and three female GP partners in this medical practice. Castlecroft Medical Practice is a teaching practice and medical students from Imperial College London spent part of their training at the practice. We were told that during 2015 the practice would also be training doctors to become GPs. Additional staff included a business manager, practice manager, five female practice nurses and a female health care assistant. There were fourteen administrative staff that supported the practice.

The practice offered a range of clinics and services including, asthma, child health and development, diabetic, contraception and minor surgery.

The practice opening times were from 8:00am until 6.30pm Monday, Wednesday and Friday and extended opening hours were provided on a Tuesday and Thursday from 8:00am until 8:00pm. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by Primecare, an external out of hours service contracted by the CCG

Why we carried out this inspection

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

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

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

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

How we carried out this inspection

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

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

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 12 December 2014. During our visit we spoke with a range of staff including GPs, nurses, business manager, practice manager and administration staff and we spoke with patients who used the service. We also spent some time observing how staff interacted with patients. We spoke with a member of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. Forms used to record significant events were detailed and recorded any follow up action taken. We reviewed two of the significant events received within the last 12 months. We saw that these had been discussed at the weekly meeting held by GPs at the practice and also at the monthly clinical staff meeting. We saw evidence to demonstrate that action had been taken as necessary, such as staff training. Information seen demonstrated that the practice had managed incidents, complaints and significant events consistently over time and so could evidence a safe track record over the long term.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

We spoke with the lead person responsible for recording and reviewing significant events. We identified that the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of the significant events that had occurred during the last 12 months. A slot for significant events was on the practice meeting agenda, information discussed included a review of actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. All staff spoken with including, administration and nursing staff, were aware of the system for raising issues and felt that they were encouraged to do so. Staff confirmed that incidents, significant events and complaints were discussed at practice meetings.

National patient safety alerts were received at the practice via email. The practice manager confirmed that they reviewed the information and cascaded the relevant safety alerts to all staff, we saw that these were available on the practice intranet. Safety alerts were also discussed at the practice staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for the relevant agencies were easily accessible on staff noticeboards around the practice.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children. All clinical staff had been trained to level 3 in safeguarding vulnerable adults and children and all administration staff had been trained to basic level 1. All staff we spoke to were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

We were told that there were no children registered at the practice on the child protection register and no vulnerable adults subject to safeguarding referrals. However, staff confirmed that there was a system to highlight vulnerable patients on the practice's electronic records which would be used if required. The practice had a system for identification and follow up for children and young people with a high number of attendances at the Accident and Emergency department and for those families, children and young people who regularly did not attend appointments. Health visitors were available at the practice on a weekly basis and we were told that GPs would share information with them as appropriate to assist in the protection of vulnerable adults and children.

A GP at the practice undertook a weekly review of patients being treated for drug and alcohol addiction. This helped to monitor their recovery and keep these patients safe.

A chaperone could be present during intimate examinations. This is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. A chaperone policy was in place and available to all staff via each computer desktop. This recorded the duties and responsibilities of a chaperone. Information about the availability of chaperones was visible in consulting rooms and was recorded in the practice leaflet which was available to all patients. Patients we spoke with confirmed that they had

been offered a chaperone. We saw training documentation to demonstrate that internal chaperone training had been undertaken by all staff. We were told that clinical staff such as nurses and the health care assistant would be called upon initially to act as a chaperone; if these staff were not available a member of reception staff would be required to act as a chaperone. Staff spoken with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. There were no checks of criminal records with the disclosure and barring service (DBS) for those administration staff who also acted as a chaperone. Following our inspection we were told that DBS checks would be undertaken on all staff and that this process had already commenced.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw that hard copies of letters and other information were scanned onto the system on the day it was received and forwarded to the GP for action. We saw that there was no backlog of scanning, coding or follow up of electronic patient information.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators. There was a clear policy for ensuring medicines were kept at the required temperatures which included the action to take in the event of a possible 'cold chain failure'. Staff spoken with were aware of and followed this policy. Records were available to demonstrate that vaccination fridge temperatures were monitored on a daily basis; we saw that records were available from 2008.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that nursing staff kept records to demonstrate this. Medicines checked on the day were all within their expiry dates. We discussed the storage of medication to be taken out by GPs on home visits. We were told about the arrangements in place to ensure secure storage and for ensuring that medication was within its use by date.

A stock rotation and control system was in place and we were told that vaccines were ordered on an as needed basis which helped to reduce the risk of overstocking. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and these were kept securely and a logging system had been implemented which kept a track of prescriptions used.

Electronic ordering of repeat prescriptions was introduced at the practice approximately six months ago. All staff confirmed that they had undertaken training regarding this. We saw that there was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Medication policies were available to all staff as required on the practice's intranet. We saw that the medication policy had been reviewed during 2014.

We were told about the shared care arrangements in place with the hospital for patients taking high risk medicines. Medicines initiated in hospital and prescribed for potentially serious conditions often require specific monitoring. At the time of discharge, and to enable the patient to return home, the medicines may be the subject of shared care guidelines requesting the transfer of prescribing to a GP while the hospital consultant retains overall clinical care of the patient. We were told about the systems in place to ensure that all necessary checks were undertaken and for the repeat prescribing of medication under shared care arrangements.

Cleanliness & Infection Control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be visibly clean and tidy. An external cleaning company were responsible for cleaning the premises. We saw that there were cleaning schedules in place and cleaning records were kept. We also saw that cleaning audits had been completed. The practice manager was able to raise any issues regarding the cleanliness of the practice with the cleaning supervisor.

Good

Are services safe?

The practice manager and head nurse were the leads for infection control. Records seen confirmed that they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the infection prevention and control lead had carried out an audit in February 2014 with a separate audit being undertaken for the room used to undertake minor surgery. Records showed that any improvements identified were completed, for example the replacement of chairs which had cloth covered seats in treatment rooms.

An infection control policy and supporting procedures were available for staff to refer to. Infection control measures in place included use of personal protective equipment (PPE) such as disposable gloves, aprons and coverings, use of spill kits and clearly labelled sharps bins.

Blood or bodily fluids such as vomit or urine could generate spills and as such need to be treated to reduce the potential for spread of infection with patients, staff or other visitors. We saw that spill kits were available in clinical areas and in the reception. Staff were aware where spill kits were stored and when they should be used. This would help to ensure that any potentially infectious substances were attended to by staff in a timely and effective manner.

All staff had received infection control training specific to their role including hand hygiene training.

A hand hygiene audit and guidance was available which enabled staff to self-assess their hand hygiene practices. Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We were told that all clinical staff were up to date with relevant immunisations and we saw records to confirm this.

We saw that clinical waste was stored appropriately in a locked room with no public access.

Systems were in place regarding the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks such as testing of water and flushing taps that were not used on a daily basis in order to reduce the risk of infection to staff and patients. We did not see a copy of the original risk assessment undertaken as we were told that the landlord of the building held this information.

Equipment

We saw records to confirm that all portable electrical equipment and fire fighting equipment was routinely tested. Fire fighting equipment checks were next due in 2015. Portable electrical appliances and equipment displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer.

We were told about recent problems with an Electrocardiogram machine (ECG) which was caused by a change to the provider's computer package. An ECG records the electrical activity of the heart and can be used to help find the cause of symptoms such as palpitations or chest pain. A representative from the patient participation group confirmed that they were fund raising to try and purchase an additional ECG machine.

Staff we spoke with told us that the equipment they used was well maintained and they felt that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing & Recruitment

There were no staff vacancies at the practice although we were told about two future vacancies due to staff retirement. We were told about the succession plans in place regarding these staff and the forward thinking that had taken place in order to provide additional support to the GPs. We saw that there was a low staff turnover with the majority of staff having worked at the practice for many years.

We looked at the recruitment information for the two most recently employed staff. Records we looked at contained evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy which had recently been implemented and which set out the standards it should follow when recruiting clinical and non-clinical staff. We

discussed DBS checks with the business manager and were told that those clinical staff who had been employed at the practice for many years had not had a DBS check undertaken. We were told that two nursing and one health care assistant did not have any form of criminal records check undertaken. We were also informed that those administration staff who undertook chaperone duties did not all have a DBS check. Following our inspection we received confirmation that the process of checking criminal records (DBS checks) had been completed for the clinical staff and DBS checks had been requested for three administrative staff. We were told that the practice were beginning a programme of undertaking DBS checks for all existing employees including administration staff who acted as a chaperone. The practice had completed a risk assessment for those administrative staff that had not as yet undertaken a DBS check.

We saw that there was no written references for one member of administration staff recently employed. We were told that this member of staff was known to other staff employed at the practice and had not previously been in full time employment; having recently left education. The business manager confirmed that character references would be sought in the future if potential staff had not been in employment.

We were told about the systems in place to ensure that the practice was sufficiently staffed at all times including during annual leave, sick leave or staff training. Administration staff spoken with said that the majority of staff were trained to undertake each other's job roles which was beneficial when a member of staff was on leave. All staff would be expected to cover each other's annual leave. We were told that there were usually enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. We were shown a copy of the administration staff duty rota which recorded the names of staff on duty and their responsibilities for the day. This helped to ensure that all duties were covered on a day to day basis.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The NMC was set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The practice also kept a record to demonstrate that GPs were registered on the performers list which demonstrates that GPs were up to date with their appraisal and revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.

The practice used a locum GP on a regular basis. Records demonstrated that sufficient checks had been undertaken to demonstrate that the locum was suitable to work at the practice. This included written references, DBS checks, training information and evidence that the locum was on the performers list. We were told that other locums were occasionally used. We saw records to demonstrate that sufficient checks had been undertaken.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. 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. We saw that risk assessments had been undertaken following an accident at the practice, this resulted in the provision of all new seating in waiting areas.

An environmental risk had been undertaken. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk, for example the replacement of carpet to stairs. We saw that any risks were discussed at GP's weekly meetings and other staff meetings.

A disability discrimination act risk assessment had been undertaken which included assessing wheelchair access, sound and visual systems for hearing and visually impaired patients at the practice. We saw that actions required were recorded. Other risk assessments completed included a legionella risk assessment and control of substances hazardous to health (COSHH) which had been completed by the company who undertook cleaning of the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received

Good

Are services safe?

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED) which is used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check 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. The plan covered both short and long term loss of premises, facilities, systems or staffing. Each risk was recorded and mitigating actions detailed to reduce and manage the risk. Risks identified included power failure, unplanned absence of staff and computer system failure. The document also contained relevant contact details for staff to refer to. We were told about an informal arrangement with a nearby practice for short term use of their facilities or if these premises were not available alternative arrangements were in place.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff had completed fire training and that a fire drill had taken place recently.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance; accessing guidelines from the National Institute for Health and Care Excellence (NICE). We were given examples of instances where NICE guidelines had been referred to and acted upon, for example blood pressure monitoring of those patients with hypertension. We were told that regular monitoring took place until it was agreed that the patient was able to attend nurse led clinics. We saw that clinical audits had been completed using NICE guidelines and criteria.

Vulnerable patients, those with long term conditions and patients over 75 years old were assessed and care plans generated to enable increased monitoring and follow up of patients.

The practice held a register of patients with learning disabilities and care plans were in place. Care plans in place for patients with complex mental health need were reviewed at least quarterly, if the patient was taking a repeat medication for mental health needs the care plan would be reviewed as required, this may include a weekly review.

The practice followed the Royal College of General Practice guidance and completed annual health checks for patients with learning disabilities, including an annual thyroid test for patients with Down's syndrome.

Systems were in place to ensure that patients suffering from long term conditions had their care needs reviewed as required. Patient care advisors were employed at the practice with the responsibility for ensuring that these patients attended relevant health checks and immunisations. The practice's prescribing policy ensured that those patients who were taking regular medication had this reviewed regularly and therefore saw a GP.

Two practice nurses had undertaken a university course regarding diabetes to further enhance the service provided to patients with this condition at the practice.

Systems were in place to ensure that the initial appointment of a pregnant patient would be with the GP. This helped to ensure that all pre-existing health conditions and prescriptions were reviewed; the GP confirmed that they would liaise with other services such as the midwife as appropriate to ensure that all care needs were considered and acted upon.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to secondary care. 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 manage them at home. These patient groups included vulnerable, older patients, patients needing end of life care and patients who were at risk of unplanned admission to hospital. A minimum of 2% of the practice's adult population (aged 18 and older), should be identified and case managed proactively.

We saw that discussions were held regarding patients who attended the accident and emergency department and patients discharged from hospital at the monthly clinical meetings. This helped to ensure that unplanned admissions and re-admissions to hospital were regularly reviewed enabling improvements to services to be identified and discussed.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had completed a number of clinical audits, for example Chronic Obstructive Pulmonary Disease (COPD) management, an audit of thiamine prescribing in patients with excess alcohol intake and an audit of type two diabetes mellitus screening in polycystic ovary syndrome patients with additional risk factors. We saw that the COPD audit had initially been completed in 2012 and a re-audit conducted in 2014. The practice was able to demonstrate changes resulting since the initial audit which had resulted in them fully meeting NICE guidance criteria for the optimum management of COPD. Conclusions were

Good

Are services effective?

(for example, treatment is effective)

recorded for other audits and lessons learnt disseminated amongst all GPs with details of action to be taken. Audits were also undertaken by the CCG prescribing advisor and changes made to practice as required.

The practice also used the information they collected for the Quality and Outcomes Framework QOF and their performance against national screening programmes to monitor outcomes for patients. To date the practice had reached a 91.7% achievement against QOF targets QOF achievement targets run from April until March each year. (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).

Staff regularly checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. Patient care advisors were responsible for making contact with patients with long term conditions and arranging relevant appointments for immunisations and health checks.

Minor surgery was completed at this practice. We were told that three of the GPs at the practice undertook this and had undertaken appropriate training. Records were available to demonstrate that additional infection control audits were undertaken in the minor surgery room to ensure infection control standards were met.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. A good skill mix was noted amongst the doctors with GPs having additional diplomas or specialist interests in diabetes, dermatology, sexual and reproductive medicine and minor surgery.

We were told by the business manager that annual appraisals were completed for all staff and we saw records to confirm this. Appraisal of nursing staff had been identified by the practice as an area for improvement. The nursing staff appraisal records that we saw did not record identified learning needs and there were no personal development plans in place. We were told that a new appraisal system had been introduced for administration staff and this was to be rolled out for clinical staff within the near future. We will review this at our next inspection of the practice. Staff that we spoke with confirmed that they were well supported, could speak to management at any time and were offered or could suggest training courses that they wished to attend.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We saw training certificates to demonstrate that staff had undertaken recent mandatory training such as manual handling, fire safety, infection control and basic life support. A training matrix had been developed which recorded all staff training completed. We saw that the majority of staff had completed safeguarding vulnerable adults and children training and times were being allocated for the remaining staff to complete e learning. Additional training had been undertaken by staff that had lead roles, for example the practice manager and practice nurse had undertaken additional training to be the nominated infection control leads.

We were told about the systems in place to review the performance of locums who had worked at the practice which also helped to ensure that patients were kept safe.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. Those with extended roles, for example seeing patients with long-term conditions such as asthma, COPD, and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. We saw that there was no backlog of information to be scanned on to the computer or to be actioned.

As well as the GP and nursing services provided at the practice, other services were available which were introduced in response to population needs. Health visitors held regular clinics at the practice and were also involved,

Good

Are services effective?

(for example, treatment is effective)

along with practice staff in assessing, planning and delivering patients care and treatment. Phlebotomy services were available as well as a counselling service, Healthy Minds and midwifery services. Healthy Minds is a psychological therapy service for people who are experiencing common mental health problems such as depression, anxiety and stress.

The practice held monthly multidisciplinary team meetings to discuss patients with complex care needs, for example those patients with end of life care needs. These meetings were attended by district nurses and community matrons. The practice's Gold Standards Framework (GSF) register was updated following these meetings. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We saw the minutes of the monthly clinical staff meetings. Both health visitors and midwives were invited to attend these meetings to share information as required.

We were told about the systems in place to refer patients for community services. Staff told us about the Wolverhampton urgent care triage and access service (WUCTAS) which gave access to community services such as the falls prevention team, district nurses and hospital at home. This helped to ensure that patients had easy access to the care that they required.

The GP told us that they referred children and young people to local services such as the child and adolescent mental health service (CAMHS) and Base 25 who provide support for people in Wolverhampton aged 11 – 25. Base 25 is a young person information and advice centre offering a daily drop in service and provides, for example counselling and Improving Access to Psychological Therapies (IAPT). IAPT is a national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders.

With effect from 1 December a new community outpatient service for dermatology was being hosted at the practice who provided rooms and a reception service.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local 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, and the practice used the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice also has signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GP we spoke with stated that clinical staff had received training regarding the Mental Capacity Act and a practice nurse spoken with confirmed this.

Clinical staff that we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

The practice had enrolled for a dementia enhanced service. This helped to ensure the timely assessment of patients who may be at risk of dementia. We were told that patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it**.** Advance care planning decisions for patients with dementia would be recorded in their care plans in line with the their wishes. We saw that all care plans for patients with learning disabilities had been reviewed within the last year.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, written consent for all minor surgical procedures. Details of all consent, including, 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. We were told about an audit which was undertaken in 2011 regarding how satisfied patients were with consent processes and explanations given regarding treatment. The GP told us that they were going to repeat this audit in the near future to identify any improvements.

The majority of patients registered at the practice were able to communicate in English; however translation services were available if required. The British sign language service was used for those patients who were hard of hearing if applicable. This helped to ensure that all patients were aware of their treatment options and gave consent upon full receipt and understanding of information.

Health Promotion & Prevention

The practice offered various health promotion and prevention services and was able to signpost patients to other available services. An in-house weight management service was provided and patients could also be referred to weight watchers. The practice had also identified the smoking status of 78% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients.

All new patients registering with the practice were offered a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner. NHS Health Checks were offered to all patients aged 40-75. Practice data showed that a third of patients registered at the practice in this age group took up the offer of the health check during the last quarter. There was a policy to offer telephone reminders for patients who did not attend for NHS Health Checks and practice nurses were responsible for following-up patients who did not attend screening

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and practice records showed that all of these patients had been offered and received an annual physical health check within the last 12 months.

The practice offered a full range of immunisations for children, travel vaccines including yellow fever, shingles and flu vaccinations in line with current national guidance. Systems were in place to follow up patients who do not attend appointments and to remind at risk patients of the availability of vaccination programmes. These systems had resulted in a high achievement against targets.

A GP at the practice had a particular interest in sexual health and completed sexual health assessments during normal clinic time. Patients would be signposted to relevant services as needed including genitourinary medicine.

We saw that waiting areas contained well-kept noticeboards with relevant up to date information, for example regarding bereavement support, health promotion flu and carers services. Leaflets were available for teenagers to promote youth friendly services. We were told that a carer's support representative regularly attended the surgery and talked to patients and to the PPG. We saw that the practice held a carers register. Staff spoken with told us how this information was used to offer carers extra support, flexibility with appointments or to ensure vaccinations were offered to try to keep them healthy.

The practice's performance for cervical smear uptake was 82% which was in line with the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and practice nurses were responsible for following-up patients who did not attend screening.

The practice's website provided health promotion and self-help information. A link to the NHS Choices website for specific conditions was available or an information leaflet could be downloaded. Information was available regarding a range of topics such as head lice, coughs, hay fever and headache. The website also signposted patients to various mental health and carers support services such as Young Minds, Mind, Carers Direct and Wolverhampton Carers. This helped patients access relevant support groups and

Good

Are services effective?

(for example, treatment is effective)

services. There was a short video on the practice website about caring and the website signposted people to Carers support groups and requested patients who are carers to inform the doctor at their appointment.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 183 patients undertaken by the practice's Patient Participation Group (PPG). The evidence from both of these sources showed patients were satisfied with the service provided, 96% of respondents to the PPG survey rated the practice as excellent or good regarding the "overall experience" and 96% would recommend the practice to someone moving into the area. Data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. Patients spoken with on the day stated that all of the staff at the practice treated them with respect.

Both male and female GPs were available at this practice and we were told that patients were offered an appointment with a clinician of the same sex as themselves. Where patients did not express a preference, a chaperone was offered if an intimate examination was required. Patients we spoke with on the day confirmed that they had been offered a chaperone as required. We saw records and staff spoken with confirmed that they had undertaken equality and diversity training and this was also discussed regularly during practice meetings. In-house training was provided to staff on how to deal sympathetically with all people who use services. Staff told us that dealing with patients in a caring and sympathetic manner is embedded in the culture of the practice and staff would be reminded of this if found to be acting inappropriately.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and all were extremely positive about the service experienced**.** Patients said they felt the practice offered an outstanding service, GPs were responsive and clear in their advice and all staff were friendly, efficient and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All told us that the practice provided good care and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy in order that confidential information was kept private. Patients that we spoke with were aware that they should stand behind the barrier and only one patient at a time was allowed to approach the reception desk. The waiting area was located away from the reception area and further shielded from the conversations taking place at the reception by a glass partition'. The television was playing which also prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. On the day of inspection we spoke with patients in a private room at the back of the reception. Administration staff confirmed that they also used this room to speak with patients in private if required or requested.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients recorded that GPs were understanding, listened and gave clear advice. The practice was rated highly for the GPs, nurses and reception staff as being polite, courteous and listening to patients.

Staff told us that translation and sign language services were available for patients who did not have English as a first language or for those patients who were hard of hearing**.** The practice website could be translated into 80

different languages. British Sign Language interpreters were made available for those who were hard of hearing. This helped to ensure that people were aware of and involved in decisions about their care.

We saw that personalised care plans were in place for patients with a view to avoiding unnecessary hospital admissions. In addition care plans for those patients with learning disability or those with complex mental health needs were available. These were reviewed on at least a quarterly basis. All patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes or asthma were invited to attend an annual review of their condition. Any medication these patients were taking was reviewed so that patients were on the most appropriate medication for their condition.

There was a palliative care register to help optimise quality of life for patients and their families via the use of symptom control and good supportive care.

We saw information leaflets in the waiting area. The information included details of advocates, groups and agencies to contact should patients require advice and support. Further information about support agencies was available on the practice website.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received showed that patients were positive about the emotional support provided by the practice. During our inspection we observed staff to be caring and compassionate.

We were told that GPs assess those with long term conditions and multi-morbidities for anxiety and depression as part of routine reviews. This helped to ensure that patient's emotional and physical health was kept under review.

Notices in the patient waiting room, on the TV screen and patient website also signposted people to 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. Good support was available to carers.

Nursing staff had received additional training regarding end of life care and bereavement support. The practice website guided patients what to do "in times of bereavement", for example registering the death and contacting a funeral director. We were told that GPs would make a telephone call or a visit to a patient who had recently been bereaved. Patients would also be signposted to other support agencies as appropriate. We saw that information regarding bereavement services was detailed on the carer's noticeboard in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. Flexibility in appointment booking, text reminders, availability of a named GP and on site phlebotomy services all helped to ensure that the needs of those patients with enduring mental illness were accommodated at the practice. Systems were in place for picking up alerts received from the clinical commissioning group (CCG) for example regarding drug users and missing persons. Alerts were placed on the practice's computer system to flag patients who may display challenging behaviours to make staff aware of possible conflict situations.

The practice provided a good range of nurse led clinics which supported the role of the GP. We saw from the minutes of practice meetings that patients with long term conditions were allocated to patient care advisors. We were told that the role of the patient care advisor was an enhancement of the traditional medical receptionist role and had the additional responsibility of ensuring a robust system of patient calling for long term conditions. Each member of the team had their own list of patients. Patients would be contacted by telephone and then letter. A system of recording contacts and attempted contacts with patients had been implemented. Patient care advisors that we spoke with told us that they had built up a good relationship with those patients on 'their list' and these patients were aware who they should contact if they had any queries.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were completed by GPs and practice nurses. Practice nurses we spoke with told us that they completed diabetic checks, spirometry, dressings and staple removal post surgery at their home visits.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the Patient Participation Group (PPG). We were told that staff rotas and duties had been changed to ensure that more staff were available to answer the telephones at peak times and a new telephone system had been put in place to allow efficient call queuing and distribution of calls between staff.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The premises and services had been adapted to meet the needs of people with disabilities. The building and treatment rooms could be accessed by patients using wheelchairs or mobility scooters. This building had been assessed as being disability discrimination act compliant . A lift provided access to all areas of the service and disabled toilets were available.

Patients are able to book appointments on line, by telephone or in person at the surgery. Those people who are hard of hearing are able to book urgent appointments by email. Extended opening hours were provided on a Tuesday and Thursday evening until 8pm. This helped those patients with work commitments access the service. Longer appointment times were given to those patients who requested this or for those who the reception staff felt would require a longer appointment time.

The practice had access to online and telephone translation services. In addition to this the practice website gave a link to the Department of Health website fact sheets which had been written to explain the role of the UK health services, the NHS, to newly-arrived individuals seeking asylum. They covered a variety of issues such as how to register with a GP and how to access emergency services.

The practice also offered online services for appointments and repeat prescription. Patients could speak with the GP over the telephone if they were unable to attend the practice, for example due to work commitments. Changes had recently been made to the appointment systems to enable easier access to appointments for patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 8:30 am to 6:30 pm on Monday, Wednesday and Friday. Extended opening hours were available on a Tuesday and Thursday until 8pm which were particularly useful to patients with work commitments. The practice used a scheme called Advanced Access and were able to offer same day and next day appointments as well as advance booking up to six weeks in advance. Patients were advised of this in the practice leaflet and on the practice website.

Comprehensive information was available to patients about appointments on the practice website. Patients were able to book and cancel appointments through the website and order repeat prescriptions. Patients could have text reminders of their appointment and the website encouraged patients to inform staff if they wished to receive this service and to ensure that their contact details were up to date. Patients were advised that there was a free app to download to allow easy access to online booking and repeat prescription services. Information was available regarding arranging urgent appointments, home visits or discussing queries with the patient's usual doctor over the telephone. When the practice was closed there was an answerphone message giving the telephone number that they should ring depending on the circumstances. The website and practice leaflet also gave information which guided patients to use the NHS 111 service or to dial 999 in an emergency. Details of the nearest NHS Walk In Centres were also recorded on the practice leaflet.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. One patient we spoke with told us that they had telephoned in the morning for an urgent appointment and had been offered a morning or afternoon appointment.

Castlecroft Medical Practice is located in a purpose built medical centre. An automatic front entrance door is provided which is suitable for wheelchair users. Two waiting areas were available; one on the ground and one on the first floor of the building. Lift access enabled patients to access all areas. Disabled toilets were provided on both floors. The practice had wide corridors and we were told that all areas were accessible for the use of patients with wheelchairs or mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

Following monitoring of the availability of appointments, changes were made to the booking system we were told that further monitoring would be undertaken to review the changes made.

We were told that students were able to register at the practice as a temporary patient outside of term time.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated lead and handled all complaints in the practice. Administration staff spoken with were aware of their role in handling complaints and confirmed that complaints leaflets were available. We were told that they had been trained to deal with difficult situations. Staff said that meetings could be arranged with the complainant and the practice manager or a GP.

We saw that information was available to help patients understand the complaints system this included information on the practice website which guided patients to speak with the practice manager if they had any concerns. Patient Advice and Liaison Services (PALS) contact details were provided in the practice leaflet. PALS provide information, advice and support to patients, their families and carers. Information regarding who the patient can go to if they were unhappy with the outcome of their complaint investigation was included in letters sent to complainants.

We looked at a sample of complaints. Complaints investigation records demonstrated that relevant staff and people who used the services were involved in any investigation as relevant. The complaints register contained detailed outcomes and action points. We found that the outcome of any complaint was explained appropriately to the complainant.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the summary of six complaints received in the last twelve months. The summary information recorded the outcome, learning points and whether or not a meeting had been held with the complainant. We found that complaints were investigated and written and/or verbal apologies were given to complainants if issues were identified.

Details of complaints and their outcome were recorded on a template. The minutes of practice meetings demonstrated that complaints were discussed at these meetings, with learning identified and acted upon as necessary.

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. All staff we spoke with demonstrated a patient centred approach to providing the service. We found details of the practice philosophy recorded in a practice charter leaflet which was available to patients on the reception desk. The practice aims were to "offer the highest standards of health care and advice to patients with the resources available".

The practice charter included information for patients regarding access to the services, complaints, comments and waiting times, for example the practice had a standard of seeing 80% of patients within 30 minutes of their appointment time, urgent appointments with a doctor would usually be offered on the same day. The leaflet also recorded patient's rights to general medical services and their responsibilities as well as some other general information about staffing and opening times.

The practice charter stated that patients would be treated with courtesy and respect by all practice personnel. The practice charter leaflet demonstrated that the service aimed to provide a caring good quality service that was accessible to all patients. Staff spoken with demonstrated a patient centred approach, were caring and showed empathy for those patients who were suffering ill health.

The practice had a vision for the future which included succession planning for staff who were due to retire**.**

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 a sample of these policies and procedures and saw that they had been reviewed annually and were up to date. The Business Manager told us that standardised policies had been purchased and they had amended the majority to meet the needs of Castlecroft Medical Practice. We were told that this was an ongoing process. We saw that these were available to staff via the desktop of any computer within the practice.

We were told about the nominated Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. Organisations that access patient records are required to have a Caldicott Guardian

We were told that the information governance (IG) toolkit training had recently been set up and staff would be completing this training shortly.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

The practice had completed a number of clinical audits, for example COPD management, an audit of thiamine prescribing in patients with excess alcohol intake and an audit of type two diabetes mellitus screening in polycystic ovary syndrome patients with additional risk factors. We saw one completed clinical audit. The practice were able to demonstrate changes made which improved patient care following the initial audit. We also saw other audits undertaken such as infection control, hand hygiene and an audit regarding consent processes. These audits helped to ensure that the practice continually monitored and developed systems and practices in place.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control; the business manager was the lead for health and safety, business planning and the building and facilities and the practice manager was the lead for complaints and the PPG. Staff we spoke with were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that GP meetings were held weekly, clinical team meetings were held monthly and separate administration staff meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Administration staff spoken with felt that they may benefit from more regular meetings with a full team of staff, which they understood was difficult to arrange due to the surgery opening hours. We saw that reviews of systems and practices had been undertaken and had resulted in the practice identifying areas for improvement which were

Are services well-led?

Good

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

shared with us during our inspection. One area for improvement identified was the need for more regular full team meetings. We were told that these meetings would be introduced in the near future.

There was an active PPG which met on a regular basis. We saw that the PPG was advertised in the practice. Members of the PPG that we spoke with told us that they received support from the practice during meetings and were kept up to date with any potential changes at the practice. We were told that the Practice staff, organised educational events for the PPG and recent events had included pain management, stroke and resuscitation training. Guest speakers had been invited to talk about the local alcohol services, a urology talk, eating disorders and dementia. Some of the guest speaks had been suggested by the PPG and some by the GP according to the needs of the practice population. We met with three members of the PPG. We were told that the practice was supportive of the PPG and that they were informed and involved in any changes at the practice. One of the PPG members told us that they had been involved in the recent employment of the Business Manager. PPG members had been invited to meet candidates prior to their interview and to give feedback to the practice manager and lead GP.

The practice had developed a newsletter and we saw a copy of the Summer 2014 information provided to patients. This newsletter updated patients regarding on-line appointments, repeat prescribing, practice survey results and other information of interest.

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

The practice used various methods to gather feedback from patients including patient satisfaction surveys, complaints and the recently introduced friends and family test (FFT). The FFT commenced on the 1 December 2014. We saw questionnaires and a collection box in the reception, along with notices asking patients to complete the questions. We saw that the practice website also had a FFT section to allow patients to submit their responses electronically if they preferred.

The practice had an active patient participation group (PPG) which had steadily increased in size and now had 20 members. The PPG contained representatives from various population groups. We were told that the age of the group ranged from 50's upwards and the representation reflected that of the wider practice demographic. One PPG member spoken with confirmed that they found it difficult to maintain group members who were from a younger age group and we were told that discussions had been held to try and encourage younger people to be involved in the PPG.

The PPG members that we spoke with told us that they had made changes to meeting times to try and accommodate all members. The PPG had carried out annual surveys and met approximately every six weeks. The results, analysis of the results and action plan were available on the practice website.

We saw minutes of meetings which confirmed that clinical staff meetings took place on a regular basis. GPs at the practice met on a weekly basis and a full clinical staff meeting was held monthly. Administration staff that we spoke with told us that they were kept informed about any changes at the practice but felt that they would benefit from a full team practice meeting as they generally met with the same few administration staff on each occasion. We saw that administration staff meetings were not held as regularly as clinical and GP meetings. This had been highlighted by the practice as an issue for action and we were told that more regular meetings would be held in the future.

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

Management lead through learning & improvement

Staff said that they received training relevant to their role. We were told that the practice was very supportive of training and staff said that they were encouraged to undertake training to further their professional development and skills.

Minutes of practice meetings demonstrated that discussions were held regarding any complaints received, significant events or incidents. This helped to ensure that the practice improved outcomes for patients. Records demonstrated that reviews of significant events and other incidents had been completed. We saw that action had been taken following risk assessments, for example all seating had been replaced in waiting areas and carpets

Are services well-led?

Good

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

replaced to stairways. From discussions with staff and review of records it was evident that the practice was open and transparent and encouraged staff to learn from incidents, complaints and audits undertaken.