# Buttercross Health Centre

## Quality Report

Behind Berry
Somerton
TA11 7PB
Tel: 01458 272473
Website: www.somertonsurgery.nhs.uk

Date of inspection visit: 2 December 2014
Date of publication: 09/04/2015

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 undertook a comprehensive inspection of the Buttercross Health Centre in the village of Somerton on 2 December 2014. The Buttercross Health Centre in, Somerton, Somerset provides primary medical services to people living within a five mile radius of the town. The practice provides services to a diverse age group.

Our key findings were as follows:

The Buttercross Health Centre operated a weekday service to over 5,050 patients in Somerton and surrounded villages. The practice was responsible for providing primary care, which included access to the GP, minor surgery, ante and post natal care as well as other clinical services. At the time of our inspection there were four female GPs, three practice nurses, two healthcare assistants, a medical director, a practice manager, and additional administrative and reception staff.

Patients who use the practice had access to community staff including district nurses, health visitors, physiotherapists, counsellors, and midwives.

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

We found that staff were well supported and the practice was well led with a clear vision and objectives. Staff had knowledge of safeguarding procedures for children and vulnerable adults although not all of the staff had received training in these areas.

Patients we spoke to and the comment cards we looked at confirmed that people were happy with the service and the professionalism of the GPs and nurses. They told us that they were always treated with kindness and respect. The practice was spacious with easy access for patients with mobility difficulties and patients with pushchairs. The practice was clean and there were effective infection control procedures in place.

There was an open culture within the organisation and a clear complaints policy.

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

The provider should:

# Summary of findings

Ensure that all staff receive up to date training in Safeguarding vulnerable adults and children

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and 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. Medicines were stored, managed and dispensed in line with national guidance. There were safeguards in place to identify children and adults in vulnerable circumstances. There was enough staff to keep people safe. Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed the practice had systems in place to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Staff employed at the practice had received appropriate support, training and appraisal. GP appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local

# Summary of findings

population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. Patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

**Are services well-led?**

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver quality care and treatment and they were looking for ways to improve. Staff reported an open culture and said they could communicate with senior staff. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care.

The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice.

# 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 providing care to older people. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people during routine appointments. Staff recognised that some patients required additional help when being referred to other agencies and assisted them with this.

**People with long term conditions**

Good

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Longer appointments were available for patients if required, such as those with long term conditions. The practice had a carers' register run by a carers champion and all carers were contacted by telephone to offer them an appointment for a carers' check with nursing staff.

**Families, children and young people**

Good

The practice is rated as good for families, children and young people. Staff worked well with the midwife to provide prenatal and postnatal care. Postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. The GPs training in safeguarding children from abuse was at the required level.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. If these appointments were not available then a telephone consultation with a GP would be booked The practice operated extended opening hours one evening a week. Males over the age of

# Summary of findings

65 years were invited to attend screening for abdominal aortic screening. The practice website invited all patients aged over 45 years to arrange to have a health check with a healthcare assistant if they wanted. A cervical screening service was available.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at team meetings. Referral to a counselling service was available. The practice did not provide primary care services for patients who were homeless as none were known. However, staff said they would not turn away a patient if they needed primary care and could not access it. Patients who needed support from interpretation services were known to the practice and staff knew how to access these services. Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as requires improvement for people experiencing poor mental health, including people with dementia. The practice was aware of their aging population group. Staff were aware of the safeguarding principles but required training. GPs and nurses had access to safeguarding policies. The practice were aware of patients that suffered poor mental health. There was signposting and information available to patients. The practice referred patients who needed mental health services. Some support services were provided at the practice, such as Talking Therapies. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines.

# Summary of findings

## What people who use the service say

We looked at patient experience feedback from the national GP survey from 2014/2015. 129 completed surveys were returned, the results showed that 97% of patients had confidence and trust in the GPs and 99% had confidence in the nurses within the practice. The patient's survey showed 33% of patients were able to see or speak to their preferred GP and only 48% said that they had a 15 minute wait to see the GP. The friends and family test results from October 2014 showed that 62% of the 298 patients that responded to the survey would be extremely likely to recommend the practice to others.

We spoke with seven patients during the inspection and met with a member of the patient participation group. We collected 13 completed comment cards which had been left in the reception area for patients to fill in before we visited. The vast majority of feedback was positive. Patients told us the staff were friendly, they were treated with respect, their care was very good, and there was much improved space in the new building. The negative themes were that the waiting time to get an appointment with their preferred GP was too long. The practice had recognised this need and employed new salaried GPs.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions from the practice.

## Areas for improvement

**Action the service SHOULD take to improve**

Ensure that all staff receive up to date training in Safeguarding vulnerable adults and children

# Buttercross Health Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team also included, a GP specialist advisor a practice manager specialist advisor, and an expert by experience (a person with experience as a patient or carer) who took part in the inspection by talking to patients and observing the surroundings.

## Background to Buttercross Health Centre

The Buttercross Health Centre is a new purpose built practice located in Somerton, Somerset. It was inspected on 2 December 2014. This was a comprehensive inspection.

Staff at the practice explained that since 2013 they had been through a turbulent time. The original partnership dissolved, the then Primary Care Trust (PCT) took over the running of the practice until the GPs and staff from the Penn Hill Surgery in Yeovil provided the GP services within the practice. Re-organisation of nearby GP practices to form the Pathways Group resulted in the Buttercross Health Centre being under their umbrella to provide services. In January 2014 performance issues were identified and this has resulted in a large number of new staff being employed within the practice.

The practice provides primary medical services to approximately 5,050 patients living within a five mile radius from the practice. There is one full time female medical director, and four part time female GPs. A male GP from another practice within the group would be available if requested. The GPs were supported by three registered nurses, two healthcare assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

The Buttercross practice is open from 8:30am to 6pm Monday to Friday with one extended evening a week with pre bookable appointments available for patients who are unable to attend during the day. During evenings and weekends, when the practice is closed, patients are directed to the minor ailment scheme provided by neighbouring pharmacies, the minor injury unit based in a nearby hospital and the Yeovil walk in centre which is open 365 days a year. For emergencies patients are directed to call the NHS 111 out of hour's service.

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning

# Detailed findings

group (CCG), Healthwatch, and NHS England. We visited the Buttercross Health Centre on 2 December 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, and patients. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

### Safe Track Record

The practice had an incident reporting process which was included in the staff handbook. Staff described how they would respond to and report safety-related incidents and told us they felt able to do so. We looked at safety incidents recorded and saw they were investigated and actions put in place to reduce the risk of them reoccurring. Staff were aware of where they could report patient safety concerns within the practice and externally if they needed to.

The Medical Director told us that when they received MHRA alerts (medical alerts about drug safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. They also shared medical alert information with other clinical staff in the practice.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw records of significant events that had occurred during 2014. The practice recorded positive as well as negative events. The weekly practice team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff for example a GP had started to do their own choose and book referrals which led to confusion with the staff and resulted in a letter being sent to the wrong patient. It was agreed in a meeting that only administrative staff would send referrals to avoid future confusion.

Complaints were discussed at team meetings and some were recorded as significant events. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. All staff were aware of the system for raising issues to be considered at the meetings and told us they were encouraged to do so.

### Reliable safety systems and processes including safeguarding

A named GP had a lead role for both safeguarding older patients and young patients. They had been trained to the appropriate level (level 3). There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local safeguarding team. These details were displayed where staff could easily find them.

The computer based patient record system allowed safeguarding information to be alerted staff. This meant that in the event a vulnerable adult or 'at risk' child is seen by different clinicians, all would be aware of their circumstances and this important information would not be lost. Not all of the staff had received training in safeguarding but we were shown evidence that training had been arranged for all staff the following month. However, they were able to tell us who the safeguarding lead was and demonstrated knowledge of how to make a referral or escalate a safeguarding concern internally.

Vulnerable patients, such as those with a learning disability, older patients who were frail or have dementia or children on the 'at risk' register, were flagged on the practice's computer system to nurses and GPs. The practice worked with external organisations through multi-disciplinary meetings such as the local social care team to share information about vulnerable children and adults.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone duties would only be undertaken by the nursing and healthcare assistants.

### Medicines Management

The GPs were responsible for prescribing medicines at the practice. There were no nurse prescribers employed. The control of repeat prescriptions was managed well. If a medication review was due a reminder was entered on the computer system for the GP to review the patients clinical records and to prompt them to take appropriate action. Patients told us they were notified of health checks needed before medicines were issued.

Patients were not issued any medicines until the prescription had been authorised by a GP, the GPs signed prescriptions twice a day. Patients were satisfied with the repeat prescription processes. Patients explained they could use the prescription drop-off box at the practice, or use the on-line request facility for repeat prescriptions. Patients could also request that their prescriptions were sent to the chemist of their choice this resulted in them not having to make an unnecessary trip to the practice.

Good

# Are services safe?

Safe management of medicines were in place. The practice nurse was responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Staff were able to show us where medicines were stored and explain their responsibilities. Medicines were kept securely in a locked cupboard. Controlled drugs were stored in the locked cupboard. Expiry date checks were undertaken regularly and recorded.

We looked at the GPs home visit bag, no medicines were carried, the GP would sign out individual medicines for patients if required.

For security purposes prescription pads were not stored in the GP consulting rooms, GPs could print a named prescription from their computer system if a hand written item was required.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date evidence that nurses had received appropriate training to administer vaccines. Fridge temperatures were also checked daily to ensure medicines were stored at the correct temperatures.

**Cleanliness & Infection Control**

Patients said the practice was always very clean. There was an infection control policy and a dedicated infection control lead who attended up to date training. Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical spillages and had spillage kits available for use. Infection control audits were undertaken.

The treatment and consulting rooms appeared very clean, tidy and uncluttered. We saw that staff knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which staff used. This reduced the risk of cross infection between patients. Within communal areas, for example the public toilets, hand washing guidance and paper towels were available.

There was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company. There were cleaning schedules in place and an infection control audit system in operation. Treatment rooms had hard flooring to simplify the clearance of spillages. Staff had received updated training in infection control.

**Equipment**

Electrical appliances were portable appliance tested (PAT) to ensure they were safe. Fire extinguishers were maintained and checked by an external company every year the last check having taken place in October 2014. We saw servicing records for medical equipment were up to date. Disposable medical instruments were stored in clinical treatment rooms in hygienic containers ready for use. We found medical equipment and supplies were within their date of expiry.

**Staffing & Recruitment**

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

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 there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

**Monitoring Safety & Responding to Risk**

Some monitoring and assessing of risks took place. For example, we saw a fire risk assessment for the premises. There was a control of substances hazardous to health (COSHH) risk assessment available for the storage of chemicals in the practice. We saw portable appliances were tested in line with Health and Safety Executive guidance to ensure they were safe.

**Arrangements to deal with emergencies and major incidents**

Good

# Are services safe?

We asked about how the practice planned for unforeseen emergencies. We were told that staff received basic life support training. We were shown a training plan to show that staff had been trained. Staff knew what to do in event of an emergency evacuation. The practice manager showed us fire safety measures and weekly testing of alarm systems. We looked at the business continuity plan and found it covered areas such as staffing, emergency procedures, access to alternative premises, disaster recovery and equipment.

**Health Promotion & Prevention**

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a nurse or with the GP if a patient was on specific medicines when they joined the practice.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients over the age of 78 years a vaccination against shingles was also available. The practice invited patients to make an appointment for these vaccinations. Patients with long term medical conditions were offered yearly health reviews. Diabetic patients were offered six monthly reviews. All registered patients over 16 years of age could request a consultation even if they have not been seen by their GP within a period of 3 years.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

There was information on external services on sexual health. Young patients are at higher risk of some sexually transmitted infections, particularly chlamydia. Patients could request testing for chlamydia and this was advertised on the patient website.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and discussion around latest guidance was included in the staff meetings. Guidance from national travel vaccine websites had been followed by practice nurses.

The GPs were aware of their responsibility to remain up to date with the latest guidelines in care.

**Management, monitoring and improving outcomes for people**

The practice routinely collected information about patients care and outcomes. The practice gathered data on the services they provided and the outcomes and collated it into an audit tool known as the Somerset Practice Quality Scheme (SPQS). This was a nationally agreed replacement for the Quality Outcomes Framework (QOF) in Somerset for one year. The medical director told us its purpose is to innovate new ways of integrated working with other providers to reduce the bureaucracy and target-chasing associated with QOF.

The practice used SPQS to focus on two work streams, integration and sustainability. The practice used the information they collected for the SPQS and their performance against national screening programmes to monitor outcomes for patients. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions.

The GP lead for medication told us clinical audits were often linked to medicines management information; the most recent audits looked into the use of a pain relieving medicine and whether an alternative medicine could be prescribed. This resulted in some patients being weaned off this medicine and an alternative medicine given.

The practice had patient registers for learning disability and palliative care. There were regular internal as well as multidisciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as local care homes and district nurses.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses such as annual basic life support but we were shown evidence that training in this area had been arranged. The GPs were up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All the GPs working within the practice were female; however the practice had arrangements in place with other practices in the group for male GPs to attend if this was necessary or requested.

All staff undertook annual appraisals, the nurse's appraiser was the community matron and the healthcare assistants were carried out by the nurses in the practice. These appraisals identified learning needs. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

The nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. Both the practice nurses had received training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines.

**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) and out of hour's providers were received both electronically and by post. The GPs were responsible for reading and taking action re any issues arising from test results and communications with other care providers on the day they were received. Staff understood their roles and felt the system in place worked well. The practice randomly audited GP notes to ensure that referrals and result letters were being managed in a timely way.

Good

# Are services effective?

## (for example, treatment is effective)

The practice worked effectively with other services. Once a month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

**Information sharing**

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage 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**

Patients told us that they were involved in the decisions about their treatment. Patients told us that the GP's explained the treatment and fully involved them in the process. They told us that they were always asked for their consent before treatment was given. Patients told us the GP and nurses always explained what they were going to do and why. Patients were able to discuss their treatment with the GP or nurse and told us they never felt rushed during a consultation. Patients said they were involved in the decisions about their treatment and care. Staff told us in order to ensure patients made informed decisions; they would provide written information to patients. We noted there was variety of health information in the waiting area.

The practice had just updated their policy for informed consent for minor surgery to include signed consent forms being scanned to the patient's records. Nursing staff requested verbal consent from parents before giving baby immunisations. Immunisations for babies and children were not given unless a parent was present or the parent had provided written consent for another family member to attend the clinic with the child.

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. They were explained the purpose of a care plan and told who the accountable GP at the practice was. The GPs had used the local memory service to assess patient's capacity and assist with the completion of these care plans.

The practice had just updated their policy for informed consent for minor surgery to include signed consent forms being scanned to the patient's records. Nursing staff requested verbal consent from parents before giving baby immunisations. Immunisations for babies and children were not given unless a parent was present or the parent had provided written consent for another family member to attend the clinic with the child.

**Health promotion and prevention**

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a nurse or with the GP if a patient was on specific medicines when they joined the practice.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients over the age of 78 years a vaccination against shingles was also available. The practice invited patients to make an appointment for these vaccinations. Patients with long term medical conditions were offered yearly health reviews. Diabetic patients were offered six monthly reviews. All registered patients over 16 years of age could request a consultation even if they have not been seen by their GP within a period of 3 years.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

There was information on external services on sexual health. Young patients are at higher risk of some sexually transmitted infections, particularly chlamydia. Patients could request testing for chlamydia and this was advertised on the patient website.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

The 2014 national GP survey for this practice received approximately129 patient responses. 94% of the patients said that they felt that the nurses showed them care and concern with 97% had confidence in the GPs. Patients completed CQC comment cards to provide us with feedback on the practice. We received 13 completed cards and the eleven were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and said that staff were considerate, helpful and caring. Patients said staff treated them with dignity and respect. Two patients told us making an appointment was difficult during the morning. Some patients were concerned about not being able to see the same GP at different appointments. Patients were complimentary about their experiences with reception staff.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow basic precautions when discussing patients' treatments in order that confidential information was kept private. Receptionists taking information to book appointments were located in a room at the rear of the reception so could not be overheard by patients in the waiting room. The practice manager told us patients were offered a room to speak with staff if they needed to discuss any sensitive information.

**Care planning and involvement in decisions about care and treatment**

Patients 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 was also positive and aligned with these views.

A GP told us how treatment plans were in place for patients planning for their end of life care, and that where the patient lacked capacity to make decisions, family, carers or the memory service were involved with the decision making process.

Translation services were available for patients who did not use English as a first language. Notices in the reception areas informed patents this service was available. A hearing loop was available for patients that were hard of hearing.

The design and layout of the reception area meant patient records could not be viewed by those attending the practice, and records were maintained securely and confidentially.

**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 were complimentary about the support they received. A patient told us that the staff had excelled in their care provision during a recent period of ill health.

Posters and leaflets were available in the waiting areas of the practice to signpost patients to a number of support groups and organisations in the area.

The practice kept a "heavenly list" of deceased patients. A GP would telephone the bereaved relative and offer support. All patients who had died were discussed in multi-disciplinary team meetings to identify and review whether their care was appropriate and whether their wishes were respected.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We reviewed the most recent data available for the practice on patient satisfaction. This included a national survey performed in 2013. We were also provided with patient feedback from the friends and family test for October 2014. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

There had been a lot of changes at the practice, a new partnership, new staff and a new building. The patient participation group (PPG) had helped with all the changes and were involved in the new build project group.

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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

**Tackling inequity and promoting equality**

The medical director and the practice manager were aware of patients who may be vulnerable or have limited access to GP practices. The practice confirmed they would offer immediate healthcare to any non-residential member of the traveller community, homeless or vulnerable patients or new migrants who were not registered at a practice.

**Access to the service**

Buttercross Health Centre's appointment system enabled patients to see a GP or nurse the same day for acute illnesses and they were advised to telephone at 08:30. There was also a same day telephone consultation system available for patients. For routine or chronic on-going problems patients were advised to telephone between 10 a.m. and 6.30 pm. Routine appointments were available up to 6 weeks ahead and this included bookable telephone consultation slots as well. Patient feedback on the day was mixed with some patients saying there was no problems with getting a same day appointment but it could take two to three weeks to obtain a non-urgent appointment. Home visits were available to patients that were too ill to attend the practice.

The practice environment had been adapted to accommodate a variety of patient needs. There was wheelchair access with automatic door entry, and the waiting room offered seating that was accessible to patients with restricted mobility. The patient toilet was accessible for patients that were wheelchair users and there were facilities for parents to change children's nappies.

The practice website contained information on the services provided by the practice, staff employed, opening times, appointments, home visits, out of hours care and how to make a complaint.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

**Listening and learning from concerns and complaints**

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

The system for raising complaints was advertised on the practice website and in the reception area. The practice manager was the designated person who was responsible for dealing with complaints from patients. We saw complaints were acknowledged and responded to. All were discussed in staff meetings to identify any learning outcomes and share these with staff. We saw from meeting minutes that complaints were discussed periodically to identify long term concerns or trends.

# 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 statement of purpose which had key principles including a delivery of best practice in patient care and patient involvement in the running of the practice. Clinical leadership and the integration of the practice's patient participation group (PPG) reflected this. The practice was aware of the challenges that would require action in the future regarding the patient population and the needs of that population. A GP had carried out a recent audit to look at the feasibility of employing nurse practitioners versus locum GPs for seeing patients requiring same day appointments. The audit demonstrated that nurse practitioners would be beneficial to patients. The plan is to employ nurse practitioners and then re audit.

**Governance arrangements**

The practice held regular clinical and administration staff meetings, the GPs and management staff met each morning before the practice opened to discuss matters arising. Weekly management meetings were held and once a month practice meetings for all staff were held to discuss significant events, complaints and other practice matters. Minutes of these meetings were kept and emailed to all staff. 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 GPs with lead roles for safeguarding and prescribing. Members of staff 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 ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. A pharmacist from the clinical commission group audited the medication weekly. One of the GPs undertook continual audits on the effectiveness of named medication being prescribed to patients to ensure that patient care is managed as well as possible.

**Leadership, openness and transparency**

Staff told us they felt there was an open culture at the practice. Staff were clear on their responsibilities and roles within the staff teams. There were delegated responsibilities within the management team and among the salaried GPs. Staff and members of the patient participation group (PPG) told us they felt the leadership at the practice were approachable and they felt engaged in the day to day running of the practice. The medical director and the practice manager attended PPG meetings to support the work of the PPG and ensure the leadership were fully engaged in patient feedback.

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

We met a representative from the PPG who explained that there was a formal PPG who met regularly and had a core membership who met bi-monthly. Their meetings were attended by the practice medical director and the practice manager. The PPG were constantly looking for different ways to increase its numbers. The PPG had been involved in assisting the practice in compiling the practice survey and analysing the results. The PPG member we spoke with was complimentary about the way the practice staff involved them in the running of the practice. They told us they felt that as a group their opinions were valued and they had a real role to play in moving the practice forward.

Staff told us they felt engaged with practice issues. They told us they could suggest ideas for improvement or concerns at their staff meetings. Staff told us that important information was reported back promptly. All of the staff we spoke with were satisfied with their involvement at the practice.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals included a personal development plans. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Clinical team meetings were used to disseminate learning from significant events and clinical audits. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits. For example, random checks are made on GP notes to ensure consultations and any referrals are recorded.