

# Millcroft Medical Centre

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Millcroft Medical Centre on 19 August 2015. Overall the practice is rated as **good**.

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

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered in line with best practice guidance. Staff had received training appropriate for their roles and any further training needs had been identified and planned.

- Patients spoke very positively about the practice and its staff. They said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available, in different languages and easy to understand for the local population.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available on the same day.
- 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.

However there were areas of practice where the provider should make improvements.

### Importantly the provider should;

- Review the extended role of the practice nurses and their responsibilities to ensure the triage role for

# Summary of findings

patients is effective. This should include also the opportunity for setting up clinical supervision practice in their work place to enable them to reflect on their practice.

- Ensure that all the required information is obtained for GP locums to establish their fitness to practice as part of their recruitment process. The practice should also develop a GP locum pack which is specific to this practice.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

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

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff routinely referred to guidance from The National Institute for Health and Care Excellence. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Systems were in place to manage, monitor and improve outcomes for patients. Effective staffing arrangements were in place. Clinical audits were carried out by the GPs along with local peer review and benchmarking of practice across the locality. All staff were involved in activities to monitor and improve patient outcomes. All staff had the necessary qualifications, skills, knowledge and experience to do their job, along with appropriate training to meet their learning needs and to cover the scope of their work.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice high in terms of how caring staff were. Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. On the day of our inspection staff showed an encouraging, sensitive and supportive attitude to patients and carers. Information to help patients understand the services was available and easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patient access to GP appointments was very good. Patients said

Good



# Summary of findings

they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice demonstrated how it learned from complaints in co-operation with staff and other stakeholders.

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. There was a clear leadership structure and staff felt supported by management. Regular practice meetings took place. The practice had a number of policies and procedures to govern activity and held regular practice meetings. All staff were allocated protected learning time and training that enabled them to deliver their duties effectively and safely. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Risk assessments were in place. Staff had received inductions, regular performance reviews and attended staff meetings, though supervision for practice nurses only took place informally.

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly experienced by older people. All patients over 75 had a named, accountable GP. The practice undertook searches of older people on their patient system, including identifying those patients who lived alone, who had caring responsibilities and who had been seen in the last 12 months. Monthly multi-disciplinary meetings took place to discuss the needs of older patients at risk of hospital admission. Older patients with chronic, complex medical conditions and social needs had their own community matron assigned to them, undertaking home visits as required. As part of their contract the practice had a Dementia Enhanced Service offering health and dementia screening to older patients and they had achieved full points for this within their Quality Outcomes Framework assessments. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, offering flu vaccination and home visits if needed.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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 monitored unplanned admissions to hospital for patients with long term conditions and those assessed as at risk of hospital admission. Any patients admitted to hospital were contacted within one week to assess if they require additional primary care support services.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were higher than the CCG average for most of the standard childhood immunisations. Patients

Good



# Summary of findings

told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice undertook a joint six week child assessment including the administration of childhood vaccines. Patient information sign posted young people to sexual health services in the area. The practice had a lead for safeguarding children and practice staff had protected time to undertake an extended role to monitor those vulnerable children at risk.

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

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offers a range of appointment times for working people including late night evening appointments for GPs and nurses each Monday, with early opening times on a Wednesday and Thursday. The practice was proactive in offering online and telephone services as well as a full range of health promotion and screening that reflected the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances and annual health checks were carried out for this population group. Staff were knowledgeable about how to support patients with alcohol and drug addictions sign posting them to support services locally. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice offered annual reviews to all patients with learning disabilities. Patients in nursing homes or who were housebound were offered a home visit for full review.

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Systems were

Good



## Summary of findings

in place to ensure people experiencing poor mental health had received an annual physical health check. This included identifying those patients on the practice register that may benefit from a dementia needs review. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice offered a full mental health support service for patients in partnership with neighbouring mental health trusts. Patients can self-refer for counselling for anxiety, stress and depression. A number of patient information leaflets and posters were available in the waiting area, sign posting patients to agencies that could provide support to the patient or their families.



# Summary of findings

## What people who use the service say

We received 34 Care Quality Commission (CQC) comment cards which included two letters from patients as part of our inspection. All of the comments made by patients were complimentary of the services provided, the staff and GPs working at the practice. Comments included how clean the practice was, how helpful reception staff were and how confident they were of the care and treatment given by the GPs and nurses. We spoke with 10 patients throughout day. Those we spoke with again told us how caring, supportive and friendly staff were and their confidence in the GPs and nurses at the practice.

During our inspection we spoke with two members of the Patient Participant Group (PPG). They told us the practice worked closely with them to develop the services for patients. We heard how the management team had listened when concerns were raised about the telephone system and a new system had been introduced. The practice had reported to the PPG the results of their patient survey and the actions taken and changes made in response to the results. The members shared their

views on how they had raised concerns on behalf of patients about trying to get through on the telephone. They explained the practice listened and were trying to make improvements to this problem.

The NHS England GP Patient Survey, published on 8 January 2015, provides up to date information on the services provided by the practice and patients view of this. Data for this survey was collected between January and March 2014, and July and September 2014. These results showed the practice performed well compared to practices of a similar size in the Cheshire area and in England. There were 350 survey forms distributed for this practice and 121 forms were returned. This is a response rate of 34.6%. The practice achieved high results for area such as waiting 15 minutes or less after their appointment time to be seen, the last GP they saw or spoke to was good at involving them in decisions about their care and the last nurse they saw or spoke to was good at listening to them.

## Areas for improvement

### Action the service **SHOULD** take to improve

- Review the extended role of the practice nurses and their responsibilities to ensure the triage role for patients is effective. This should include also the opportunity for setting up clinical supervision practice in their work place to enable them to reflect on their practice.
- Ensure that all the required information is obtained for GP locums to establish their fitness to practice as part of their recruitment process. The practice should also develop a GP locum pack which is specific to this practice.

# Millcroft Medical Centre

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The inspector was accompanied by a specialist GP and Practice Manager Advisor.

### Background to Millcroft Medical Centre

Millcroft Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 14539 patients living in and near Crewe city centre. The practice has seven GPs both male and female, a practice manager with supportive management team, one nurse practitioner and two practice nurse, administration and reception staff. The practice holds a General Medical Services (GMS) contract with NHS England.

The practice opening hours are Monday to Friday from 8am to 6.30pm each day with extending hours on a Monday evening till 8pm and Wednesday and Thursday morning starting at 7am. The practice treats patients of all ages and provides a range of primary medical services. The practice is part of NHS South Cheshire Clinical Commissioning Group (CCG). The practice population has a higher than national average patient group aged under 18 years. There are slightly higher deprivation scores for patients in this area compared to national figures.

### 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

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

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

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

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

## Detailed findings

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 19 August 2015.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face before and during the inspection. We looked at survey results and reviewed CQC comment cards

completed by patients to share their views of the service. We spoke with the GPs, nurses, administrative staff and reception staff on duty. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We explored how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

# Are services safe?

## Our findings

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff were clear that the practice manager and GP would be notified when events occurred. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and evidenced a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, including significant events and there was a proactive approach to this. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Staff reported an open and transparent culture when accidents, incidents and complaints occurred. Mostly staff told us that if an incident occurred or a patient complaint was made it would be reported to the practice manager or GP on duty. We noted the practice had a record for staff to complete should an incident occur, though not many staff other than the management team completed this. The practice was aware of this and had discussed this at team meetings to make improvements. We looked at a number of reports that were completed and we were satisfied that appropriate actions and learning had taken place.

### Reliable safety systems and processes including safeguarding

There was a local policy for child and adult safeguarding. This referenced the Department of Health's guidance. Staff had undertaken electronic learning regarding safeguarding of children, including adult safeguarding training. There was a chaperone policy in place and there were signs for this in each consultation room and in reception. The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children with appropriate training. The lead safeguarding GP was aware of vulnerable children and adults registered with the practice and safeguarding records demonstrated good liaison with partner agencies such as the police and social

services. There was a system to highlight vulnerable patients on the practice's electronic records and staff gave good examples of how this vulnerable group of patients was supported in the practice. This alerted staff to any relevant issues when patients attended appointments, for example children subject to child protection plans.

### Medicines management

The practice had clear systems in place for the management of medicines. There was a system in place for ensuring a medicines review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank holidays). The practice met on a quarterly basis with the Medicines Management team from the Clinical Commissioning Group (CCG) to review prescribing trends and medicines audits.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw that fridge temperatures were monitored daily to ensure safety. Weekly and monthly reviews of medicines were recorded. The fridge was adequately maintained and staff were aware of the actions to take if the fridge was out of the correct temperature range.

We observed effective prescribing practices in line with published guidance. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Information leaflets were available to patients relating to their medicines. We reviewed the doctor's bags available to GPs when doing home visits and found they routinely carried medicines for use in patients' homes.

Clear records were kept when any medicines were brought into the practice and administered to patients. Processes were in place to check medicines were within their expiry date and suitable for use. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. All prescriptions were reviewed and signed by a GP before

## Are services safe?

they were given to the patient. We saw that blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had the equipment and in-date emergency drugs to treat patients in an emergency situation.

### Cleanliness and infection control

The premises were clean and tidy and cleaning schedules were in place. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a staff member with lead responsibilities for infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw that the lead for infection control carried out an infection control audit in July 2015, the practice identified a number of environmental risks relating to the premises which was passed to the building manager for action and repair.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves. There was a policy for needle stick injury. Hand washing techniques signage was displayed in staff and patient toilets and hand hygiene audits were carried out by the lead nurse. Hand washing basins with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records showed that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometers.

### Staffing and recruitment

The practice had a recruitment policy in place. Appropriate pre-employment checks were undertaken, such as medical

checks, professional registration checks, photographic identification, though references for some staff were not in place. The practice undertook a Disclosure and Barring Services check for all clinical staff and a risk assessment was in place to support the decision not to undertake this for administration and reception staff. These checks provide employers with access to an individual's full criminal record and other information to assess their suitability for the role. On the day of the inspection we found there had not been any GP locum use for some time. We were told the practice does not routinely use locum GPs and those used in the past had worked for the practice for many years. However, information relating to their fitness to practice and a GP locum induction pack with information specific to this practice was not in place.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular 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.

### 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 training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and events which might prohibit access to the building. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff clearly outlined the rationale for their treatment approaches and were up to date with best practice. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. The practice clinicians worked together as a team with regular clinical meetings to discuss patients care.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. The practice profile showed that the practice was in line with referral rates to hospital and other community care services for all conditions. All GPs we spoke with used national standards for the referral of different specialities. We spoke with the GPs about how this was achieved and monitored.

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

### Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling

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

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice undertook an audit of patients who had developed a deep vein thrombosis and the care and treatments they should get in line with NICE guidelines. Results showed improvements were required for the practice and other agencies involved in the patients care package. The audit is to be required in December 2015.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. We saw an audit regarding the prescribing of anti-coagulant medicines for atrial fibrillation (heart condition) which focused on drug treatment to prevent the potential complications of stroke and it was carried out in April 2015 and is planned to be repeated in July 2016. The practice undertook a patient search to identify those patients with this diagnosis. This audit highlighted there were a number of patients who needed their medications reviewed in order to comply with the new NICE Guidelines for atrial fibrillation. Clinical reviews and further tests were undertaken for each patient and those at increased risk were invited into the practice to discuss their treatment with the GP.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. This included all of the practice chronic disease management for conditions such as asthma, diabetes, high blood pressure and respiratory diseases.

The team was making use of clinical audit tools, annual appraisals and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a



# Are services effective?

## (for example, treatment is effective)

group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation that all clinical staff should undertake at least one audit a year. We noted that the extended role of the practice nurses and their responsibilities to undertake a triage role for patients had not been audited to ensure its effectiveness and this was discussed with the practice team.

The practice's prescribing rates were also similar to what was expected for a practice this size. For example the number of Ibuprofen and Naproxen Items prescribed as a percentage of all non-steroidal anti-inflammatory drugs items was 77.05 compared to 71.5 nationally. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had a palliative care register and had monthly internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital. Individual multi-disciplinary care plans were put in place by the GPs to try to avoid any further hospital admissions. Structured annual reviews were also undertaken for people with long term conditions such as patients who had diabetes or asthma.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation, as required by the GMC. All staff had annual appraisals which identified learning needs from which action plans were documented.

Staff interviews confirmed that the practice was proactive in providing training for relevant courses. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines, or cervical cytology or assessing patients with long term conditions.

### Working with colleagues and other services

There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet patients' needs. We saw effective communication, information sharing and decision making about who might best meet the patient's needs. We saw good communications with the out of hours services with information about the patient being shared with the practice each day by 8am. This included important information for instance for patients on the end of life care pathway whose needs may have changed overnight. Information received from other agencies, for example accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. We saw that practice nurses followed up every patient who had been admitted to hospital to ensure they were well supported and to avoid a further readmission if their condition deteriorated. Information was scanned onto electronic patient records in a timely manner because the administration roles included designed staff for this activity.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and information from out of hour's providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in the passing on, reading and actioning of any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The practice had a system in place to ensure all patients discharged from hospital were seen and their conditions reviewed.

The practice attended various multidisciplinary team meetings at regular intervals to discuss the needs of complex patients, for example those with mental health

# Are services effective?

## (for example, treatment is effective)

needs and palliative care patients. These meetings were attended by community mental health staff, as district nurses, health visitors, social workers and end of life care nurses.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hour's provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out of hours services. For patients who were referred to hospital in an emergency, there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency, (summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

### Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. All clinical staff 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). There was a practice policy for documenting consent for specific interventions. For example, for minor surgery a patient's written consent was obtained and documented.

### Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and information in the waiting area about the services available. The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services, how to access them and how to direct patients to relevant services.

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. 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 a learning disability they were all offered an annual health check. The IT system prompted staff when patients required a health check such as a blood pressure check and arrangements were made for this.

Patient and population group registers were in place to enable the practice to keep a register of all patients requiring additional support or review, for example patients who had a learning disability or a specific medical condition such as diabetes. Practice records showed that those who needed regular checks and reviews had received this and the IT system monitored the progress staff made in inviting patients for their annual health review. This included sending letters and telephone calls to patients to remind them to attend their appointments. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for the cervical screening programme was 84%, which was in line with the CCG at 81%. The practice was aware of this and lengthy discussions took place with GP partners about their efforts to improve this.



# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

Consultations took place in designated rooms with a couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients despite the reception area being open plan. Patients were asked to stand some way away from the desk to avoid overhearing other patient conversations. 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 reviewed the most recent data available for the practice on patient satisfaction. This included data sources such as the national patient survey, the practice survey and the CQC comments cards completed during our inspection. Overall patients reported being treated by staff with dignity and respect and in general they were satisfied with the care they received. Most commented on how practice staff had known them and their families for many years and they felt confident in the care they received. The national GP patient survey reported that 91% of patients had confidence and trust in the last GP they saw or spoke to in line with CCG and national results and 78% say the last nurse they saw or spoke to was good at treating them with care and concern (in line with local and national results).

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

Patients we spoke with felt confident they had been involved in any decisions about their treatment and care. The national GP patient survey showed that:

- 81% said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 84% National average: 84%).
- 90% of patients said the last GP they saw or spoke to was good at giving them enough time (CCG average: 86% National average: 85%).

- 85% said the last GP they saw or spoke to was good at listening to them (CCG average: 88% National average: 87%).
- 89% said the last GP they saw or spoke to was good at explaining tests and treatments (CCG average: 83% National average: 82%).

Patients we spoke with 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke with and the comments cards we received during the inspection were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GPs. They told us all the staff were compassionate and caring.

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

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood by staff, who had worked at the practice for many years. Systems were in place to address identified needs in the way services were delivered such as for patients who lived local in local care homes. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the annual patient survey. For example in response to patients' complaints about the long wait for telephones to be answered the practice undertook an audit to review the numbers of calls that were not getting through with the current telephone system.

### Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. The GP partners encouraged staff to try to accommodate all patients' needs when they attend the surgery such as those who might be homeless or vulnerable. The practice had a large population of Eastern Europeans patients and we spoke about how language barriers sometimes required more time for staff to respond too. We saw that information was available in different languages and staff had access to language line to support their communications with patients. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. The main parts of the practice were situated on second floor of a modern and purpose built premises. The practice had wide corridors easily accessible for patients with wheelchairs. Accessible toilet facilities were available for all patients attending the practice.

### Access to the service

The practice opening hours are usually 8am to 6.30pm with extended hours on a Monday and Wednesday to accommodate working patients. Other times the practice is open from 8am to 6.30pm. Opening hours met the needs of the practice population and were clearly stated and seen on a poster in the patient waiting room. If a child required an appointment they were always seen on the same day. If required, longer appointments were available for patients who needed them and those with long-term conditions.

This also included appointments with a named GP or nurse. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was provided to patients. There was a strong commitment from GPs that patients should have good access to services provided at the practice. Patients we spoke to were aware of this and reported they were always able to see a GP of their choice at a time that was convenient to them. They told us the appointment system was easy to use and some patients were using the new online appointments system. Patients had access to an appointment with the GP or nurse practitioner when needed and a high number of telephone consultations were taking place by GPs at the patient's request.

We spent time in the patient waiting room and spoke with patients about their views and experiences. The room was bright and had adequate space, the reception area was open plan and reception staff tried to respect patient confidentiality during conversations. The area was large enough to meet the patient demands during our inspection. The area had reading materials and the walls displayed patient information. Patient leaflets were available making this an accessible and comfortable area for patients to wait for appointments. The receptionists had a pleasant and helpful manner both in their interactions with patients attending the practice and during telephone conversations.

NHS England carries out a GP Patient Survey annually. The data we hold was published on 8 January 2015. Data related to access gave results showing that 57% of patients found it easy to get through to this surgery by phone (Local (CCG) average: 61% National average: 71%). Patients (64%) described their experience of making an appointment as good (CCG average: 69% National average: 73%).

The practice had a website which displayed information for patients on a range of subjects including, opening times, the clinics available, general information about the practice including photographs of the GPs and the practice.

### Listening and learning from concerns and complaints

## Are services responsive to people's needs? (for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, this included a patient complaints leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a five complaints received in the last 12 months and found that timely and appropriate responses had been made. For many complaints a full investigation had taken place and the incident was reported as a serious event enabling the practice to identify the root cause of the concern. The response made to patients when things went wrong was sensitive, honest and open. The learning that took place was shared with the person who had complained. We were clear that listening and learning had taken place following a patient complaint.

# 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 did not have a written vision or strategy but staff shared the same ethos to provide good and sensitive patient care and to deliver high quality care and promote good outcomes for patients. We spoke with many members of staff and they all knew and understood the ethos and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at a sample of these and spoke with staff who confirmed they knew how to locate them. Some important policies and guidance such as safeguarding were also available in paper format and displayed around the practice.

The practice had a clear leadership with named members of staff in lead roles. For example, there was a lead nurse for infection control and a lead GP for safeguarding. Much of the management of practice staff was the responsibility of the practice manager. 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 nurse told us about a local peer review system they took part in with neighbouring GP practices. Benchmarking and peer support was given at these meetings and the practice made the time to ensure the nurse attended.

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 or at times above average with national standards. We were told that QOF data was regularly discussed at practice team meetings but these were informal meetings and no notes were made of this. The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the anti-coagulation therapy and the DVT audit. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place

to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing. The practice held monthly staff meetings where governance and serious events analysis issues and risks were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

### Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues via an open door policy operated by the practice manager. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. It had an active PPG which included representatives from various population groups such as the working population and older people. The PPG met bi-monthly, all meetings were noted and they

# Are services well-led?

Good 

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

produced an informative patient leaflet. The practice manager showed us the analysis of the last Family and Friends Test, which asks the question whether patients would recommend this service to friends and family and the findings were considered in conjunction with the PPG. The practice along with the PPG undertook a patient survey in June 2015. The results showed patients had concerns about getting through on the telephone, making appointments and waiting times. The report produced by the practice and the PPG shows what actions they have taken in response to these negative comments. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice gathered feedback from staff on an informal basis and formally during regular staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

There was an open and no blame culture and staff felt supported to raise concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

## **Management lead through learning and improvement**

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff had access to a programme of induction, training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff were appraised for their performance annually, this was a positive experience and their learning and development needs for the following year were identified at this time. Most staff were supervised by their line manager and informally the practice nurses would be supervised and supported. However, formal clinical supervision for this staff group was not taking place. The practice had completed reviews of significant events and other incidents and shared with staff via team meetings to ensure the practice learned from such events which led to improved outcomes for patients.