Cornerstone Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Detailed findings from this inspection

Our inspection team 8

Background to Cornerstone Medical Practice 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Cornerstone Medical Practice on 21 October 2014. We found that the provider was performing at a level which led to a ratings judgement of Good.

Our key findings were as follows:

- The practice was safe, staff reported incidents and learning took place. The practice had enough sufficient staff to deliver the service.
- The practice was effective. Services were delivered using evidence based practice.
- The premises was clean and fit for purpose and equipment was available for staff to undertake their duties.
- Staff were caring and compassionate, treated patients with kindness and respect and we saw good examples of care.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice.
- The practice was well led, with an accessible and visible management team, governance systems and processes are in place and there is performance and quality management information available. Quality was high on the practice agenda.

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 safe. 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. There were enough staff to keep people safe.

The management of the practice had ensured that there were safeguarding procedures in place and had taken steps to ensure that staff followed these. Staff had received training in safeguarding children and vulnerable adults.

Patients that we talked with told us that they felt safe. There were effective medicines management processes in place, arrangements in place to deal with foreseeable emergences and equipment was checked and maintained. The practice was clean and well-maintained.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of mental capacity and the promotion of good health.

There were enough qualified, skilled and experienced staff to meet patient's needs. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients.

Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Patients we spoke with during our inspection and CQC comment cards reflected 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.

Summary of findings

We also saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained.

Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Patients reported acceptable access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

We found that the practice had an effective system to ensure that, where needed, the GP could provide a consultation in patient's homes.

Staff were knowledgeable about interpreter services for patients.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

We found the practice worked well with other agencies and health providers to provide support and access specialist help when needed. We found that treatment and care was delivered in line with the patient's needs and circumstances, including their personal expectations, values and choices.

Where older people had complex needs then special patient notes or summary care records were shared with local care services including the out of hours provision. End of life care information was shared with other local services.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. For children and young people Gillick assessments were completed.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients registered with the practice people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients who were using the service on the day of our inspection and reviewed 36 completed CQC comment cards. The patients we spoke with were complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect. The comments on the cards were also very complimentary about the service provided. However there were some comments that the practice did use locums on a frequent basis.

National GP survey results published in July 2014 indicated that the practice was best in the following areas:

- 80% of respondents usually wait 15 minutes or less after their appointment time to be seen, CCG (regional) average: 66%
- 87% of respondents find it easy to get through to this surgery by phone, CCG (regional) average: 74%
- 86% of respondents say the last nurse they saw or spoke to was good at listening to them , CCG (regional) average: 80%

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas:

- 37% of respondents with a preferred GP usually get to see or speak to that GP, CCG (regional) average: 61%
- 76% of respondents say the last GP they saw or spoke to was good at treating them with care and concern, CCG (regional) average: 84%
- 80% of respondents say the last GP they saw or spoke to was good at giving them enough time, CCG (regional) average: 87%

Over the last year three comments had been posted by patients on the NHS choices website. None of the comments were positive about the practice and two mentioned how difficult it was to get an appointment. However the practice did respond to this comment and informed the person that there was a service available if required and that an appointment can be made to suit the needs and circumstances of the patient. The CQC comment cards we reviewed did not indicate that it was difficult to get an appointment.

Cornerstone Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector accompanied by two specialist advisers, a GP and a practice manager, and an expert by experience who is a member of the public trained by the CQC.

Background to Cornerstone Medical Practice

Cornerstone Medical Practice has 1,848 registered patients and is part of Salford Clinical Commissioning Group. There is one GP, a practice manager, a practice nurse and assistant practitioner and supporting administration and reception staff. One of the administration staff is also trained as a phlebotomist and delivers this service one day per week and on an ad hoc basis when requested by the GP. The practice works with another practice, where the GP is also the registered manager. These practices cover each other's duties when required to ensure continuity of services.

The practice delivers commissioned services under the Personal Medical Services (PMS) contract.

The practice offers a range of services for its patient population. Cornerstone Medical Practice is registered with the CQC as a provider of primary medical services. The GP is also legally responsible for making sure the practice meets CQC requirements as the registered manager.

The practice is registered with the CQC as a provider of primary medical services that includes the following regulated activities:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Treatment of disease, disorder or injury

The Practice is open as follows:

- Monday 08:00 – 18:30
- Tuesday 08:00 – 18:30
- Wednesday 08:00 – 12:30
- Thursday 08:00 – 18:30
- Friday 08:00 – 18:30
- Weekends closed

Patients can book appointments in person, via the phone and online. The practice makes every effort to see patients within 48 hours of their request. Urgent appointments are available following the initial request being assessed by the GP. Appointments can be pre-booked up to 4 weeks in advance or patients can contact the surgery at any time to request an appointment. Emergency appointments are available each day by ringing at 08:00. There is an out of hours service available provided through the NHS 111 service.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Salford Clinical Commissioning Group (CCG) information showed the practice rated as an achieving practice.

Why we carried out this inspection

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

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

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

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

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

How we carried out this inspection

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

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also 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. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 21 October 2014.

During our visit we spoke with a range of staff, including the GP, nursing and administrative staff and spoke with six patients who used the service. We also reviewed information from the completed CQC comment cards. We observed how people were being cared for and talked with carers and/or family members.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This information included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Information from the quality and outcomes framework, which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example the practice suffered the loss of telephone systems. This was reported in accordance with the continuity and recovery plan and a contingency plan put in place until the system was restored. This demonstrated how staff acted appropriately and quickly and that procedures followed were fit for purpose.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. Significant events were discussed at the practice meeting. We saw that all events had been brought to a satisfactory conclusion, and any actions that were implemented as a consequence to prevent recurrence. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. For example a podiatrist had not attended for a booked clinic resulting in patients being delayed in being seen or needing to be rebooked. The practice nurse saw patients instead if they could not wait or could not be rebooked. The practice offered apologies to the patients at the time. This service had been withdrawn but a further clinic date was scheduled in error. This was communicated to the practice team at the next meeting to prevent recurrence .

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

From the review of complaints information we saw that the GP ensured complainants were given full feedback and asked for detailed information about their concerns. We saw that the practice then checked if the complainant was satisfied with the outcome of the investigations and any actions made to improve the service.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked all staff members about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice GP was the lead for safeguarding vulnerable adults and children. The GP had received level 3 safeguarding vulnerable adults and children training. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The GP attended multi-disciplinary safeguarding meetings when required.

There was a system in place to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example the practice had received information from a Multi Agency Risk Assessment Conference (MARAC) about a patient who was at high risk of domestic violence. The MARAC meeting helps

to ensure that high risk victims are supported and better protected from further abuse by a coordinated effort from all agencies and organisations. This information was taken into account when the patient was seen.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all staff. If patients required a chaperone then this was documented and held in their records.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, Vision, and collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

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 maintenance of the cold chain and action to take in the event of a potential failure. We also saw that the temperature of the fridges, used specifically for the storage of medicines and vaccines, were regularly checked and recorded. Cold chain protocols were strictly followed. We saw written records of these and this was confirmed by staff. The "cold chain" is the process of keeping medicines within an acceptable temperature range.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by the practice nurse using protocols that had been produced in line with legal requirements and national guidance. The assistant practitioner also administered vaccines under protocols which had been reviewed and approved in line with national guidance and legal requirements. We saw evidence that practice nurse and assistant practitioner had received appropriate training to administer vaccines.

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. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed.. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. The practice did not accept prescription requests by telephone.

All prescriptions were reviewed and signed by the GP before they were given to the patient. 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 established a service for people to pick up their dispensed prescriptions at the local pharmacy and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure people collecting medicines from these locations were given all the relevant information they required.

Cleanliness & Infection Control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received, during induction, training about infection control specific to their role. We saw evidence the lead had carried out infection prevention checks (audits) and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection prevention measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury. The practice had access to spillage kits to enable

staff to appropriately and effectively deal with any spillage of body fluids. We saw sharps containers that were labelled correctly and not overfilled. There had been no reported incidents from sharps injuries or spillage.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The consulting and treatment rooms were clean and well maintained with appropriate floor and surface coverings.

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. We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. Legionella testing had taken place in February 2014.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment which included blood pressure monitors, weighing scales, pulse oximeter and the spirometer. This ensured readings taken from this equipment were accurate. We also saw that the vaccine refrigerators were regularly checked, calibrated and serviced.

We also saw that fire and intruder alarms were regularly tested, checked and serviced. There were also checks of fire extinguishers

Staffing & Recruitment

There was a practice recruitment policy in place that followed the principles of The Equality Act 2010, Employment Rights Act 1996, Human Rights Act 1998, General Medical Services Contracts Regulations 2004 and Personal Medical Services Agreements Regulations 2004.

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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff had a DBS check.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. The practice works in co-operation with another practice which the GP is also the registered manager and both practices cover each other's duties when required to ensure continuity of services. If the GP was not available then cover is provided by locum doctors.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included 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 as an identified health and safety representative.

Identified risks were recorded. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings. For example, the practice had reviewed recent findings from an infection control audit and worked through how to address the recommendations. There was also an example were it was highlighted that the reception desk was low and could be easily crossed by an individual. The practice response was to install a panic button for the safety of staff.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxic shock. Staff that would use

the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest.

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 an automated external defibrillator, used to attempt to restart a person's heart in an emergency. Staff that would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest. Emergency oxygen complete with adult and paediatric masks was stored at the main reception. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. We reviewed the practice continuity and recovery plan that confirmed this. This included contingencies in what to do in the event of loss of the surgery building, loss of computer system, loss of access to paper medical records, loss of equipment and utilities. It also had information on what to do if the GP or other member of staff became incapacitated. It also detailed what to do in the event of fire or flood and response to an epidemic/pandemic and response to a major incident

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that demonstrated staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GP told us they lead in specialist clinical conditions such as diabetes, heart disease and asthma and the practice nurse and assistant practitioner supported this work which allowed the practice to focus on specific conditions. The practice had management plans in place to support those patients with long term conditions such as asthma, diabetes, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and those who suffer from long and enduring mental ill health.

We saw that the staff had developed an extremely effective way of monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example the annual health checks and smears. There were systems in place to follow up by letter and then by telephone those who did not attend.

The practice was knowledgeable about health needs of older patients. They had information on patients' health conditions, carers' information and whether patients needed home visits. They used this information to provide services in the most appropriate way and in a timely manner. Staff were also able to recognise signs of abuse in older people and knew how to refer these concerns.

Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed.

The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed.

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

Management, monitoring and improving outcomes for people

We found that people's care and treatment outcomes were monitored and that the outcomes were compared (benchmarked) against Clinical Commissioning Group (CCG) and national outcomes.

The practice participated in clinical audit which led to improvements in clinical care. We saw evidence that the practice acted upon the results of clinical audits, and that they undertook follow up audits to ensure the management and monitoring of services to improve outcomes for patient was effective The results of audits were shared with the team through practice meetings and via email.

We examined evidence that indicated that the treatment outcomes for the practice were within expected norms and also sustained over time. Information from Quality and Outcome Frameworks (QOF) quality and productivity (QP) indicators supported this. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Effective staffing

Practice staffing included medical, nursing 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. The GP was up to date with their yearly continuing professional development requirements and had a date for revalidation. The practice used four regular locums to cover appointments when the GP was not available. The practice had actively tried to recruit a permanent salaried GP and was now in the process of advertising for one on a third occasion. The practice also had extra GP services available to cover winter pressures according to the needs of the patients.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We looked at eight staff training records, passports, that documented the training of all staff. It included core training such as infection control and safeguarding children and vulnerable adults and health and safety. We also saw evidence of staff being trained in other disciplines such as ambulatory blood pressure monitoring (ABPM), good clinical practice (GCP) and cervical screening.

The practice nurse and assistant practitioner had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. The training records we examined confirmed this

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning 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. We did not see any instances within the last year of any results or discharge summaries which were not followed up appropriately.

The GP attended Clinical Commissioning Group meetings when required and if the GP was unavailable then the practice manager would attend on their behalf. The practice manager also attended a local practice manager forum monthly to share good practice and innovative ideas. The practice nurse attended a practice nurse forum monthly and we saw that these meetings enabled good practice to be shared amongst local colleagues.

The practice held multi-disciplinary meetings when necessary and these included discussions about the needs of complex patients for example those with end of life care or palliative needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice was commissioned directed enhanced services. Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract. The practice participated in the alcohol-related reduction, avoiding unplanned admissions, facilitating timely diagnosis and support for people with dementia, learning disabilities health check and patient participation schemes. They also participated in the public heath schemes that included vaccination programmes such as hepatitis B for new born babies, measles mumps and rubella (MMR) for aged 16 and over and pertussis for pregnant women.

Referrals were made using the Choose and Book service. We saw evidence of the practices referral process and its effectiveness such as patients needing urgent cancer referrals.

We found the practice worked well with other agencies and health providers to provide support and access specialist help to older people when needed. We found that treatment and care was delivered in line with the patient's needs and circumstances, including their personal expectations, values and choices.

Where older people had complex needs then special patient notes or summary care records were shared with local care services including the out of hours provision. End of life care information was shared with other local services.

The practice was knowledgeable about the health needs of patients with long term conditions. They worked with other health services and agencies to provide appropriate support.

Information Sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, Vision, was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. 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.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. 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. We saw that the GP and practice staff ensured consent was obtained and recorded for all treatment.

Health Promotion & Prevention

The practice demonstrated a commitment that ensured their patients had information about a healthy lifestyle. This included providing information about services to support them in doing this. There was a range of information available for patients displayed in the waiting area and on notice boards in the reception areas. This included information on children's health and immunisation, long term conditions such as asthma, information for people who suffer from mental ill health and learning disabilities, and general health promotions that included smoking cessation, bowel cancer, diabetes and alcohol awareness. They also provided information to patients via their website and in leaflets in the waiting area about the services available.

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. Staff we spoke with were knowledgeable about other services and how to access them.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice worked proactively to promote health and identify those who require extra support, for example those with long term conditions. There was evidence of appropriate literature and of good outcomes for these areas as demonstrated in the QOF data.

The practice offered a range of vaccinations for foreign travel. The practice nurse was the lead for this and provided advice and information regarding foreign travel. Appointments for these were made with the practice nurse so that immunisation could be completed.

The practice nurse team also offered a variety of health checks for patients that included blood pressure checks, well woman checks, diabetic reviews and asthma checks. There was a system in place to recall to review which included those patients diagnosed with Chronic obstructive pulmonary disease (COPD), mental ill health, a learning disability, and those that required a repeat x ray.

Good

Are services effective?

(for example, treatment is effective)

The practice did routinely offered NHS Health Checks to all its patients aged 40-75. All patients suffering from a long and enduring mental illness and those with a learning disability were offered a physical health check every twelve months.

Health promotion advice and information was available for people experiencing poor mental health, including people with dementia, which included information about MIND, a mental health charity.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 36 completed cards and the 33 were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

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

Care planning and involvement in decisions about care and treatment

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

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. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services through 'Language Empire' were available for patients who's first language was not English.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted the GP 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 families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments. Longer appointments were available for people who needed them and those with long term conditions. All patients needing to be seen urgently were offered same-day appointments.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations. During our inspection the assistant practitioner was preparing to go to patient's homes to administer the flu vaccination for those people whose condition precluded them from attending the practice.

Each patient contact with a clinician was recorded in the patient's record, including consultations, visits and telephone advice. The practice had a system for transferring and acting on information about patients seen by other doctors and the out of hours service. There was a reliable system to ensure that messages and requests for visits were recorded and that the GP or team member received and acted upon them. The practice had a system in place for dealing with any hospital report or investigation results which identified a responsible health professional and ensured that any necessary action was taken. The was a system to ensure the relevant team members were informed about patients nearing the end of their life. There was also a system to alert the out of hours service and duty doctor if somebody was nearing the end of their life at home.

Tackling inequity and promoting equality

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice provided appropriate access and facilities for patients with disabilities.

Access to the service

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. 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-hours service, provided through the NHS 111 service, was available for patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice nurse treated patients for a wide range of common conditions and appointments can be booked up to a month ahead.

The national GP survey results published in July 2014 showed that 87% of patients said it was easy to get through to the practice to make an appointment. 89% of patients said they found the receptionist helpful once they were able to speak with them. Patients we spoke with showed that patients did not have difficulties in contacting the practice to book a routine appointment.

When necessary longer appointments were given to older people and home visits had been arranged if necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided a range of services for patients of working age, including those recently retired, to consult with GPs and nurses, including on-line booking and telephone consultations. Patients were also able to book a consultation with a GP through the extended hours service. The appointments system was regularly reviewed to try to maximise timely access to services for this population group.

The practice was situated on the ground floor of the building. The practice had wide corridors for the use of patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of 76% English speaking patients though it could cater for other different languages through translation services.

Listening and learning from concerns & complaints

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

Patients we spoke with knew how to raise concerns or make a complaint. Information on how to complain was displayed in the reception area and in the practice information leaflet. We looked at four complaints received in the last twelve months and found they had been satisfactorily handled and dealt with in a timely manner. For example there were two complaints about the attitudes of locum doctor's used. Each person received a letter of apology from the practice and was resolved to the satisfaction of the patient and the matter was addressed with the locum doctor by the GP.

Patients were informed about the right to complain further and how to do so, including providing information about relevant external complaints procedures. Whilst none of those spoken with had needed to complain, they all said they would be able to talk to the staff if they were unhappy about any aspect of their treatment.

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 to deliver high quality care and promote good outcomes for patients. This was to provide and deliver general practitioner services to the patients registered at Cornerstone Medical Practice. The aim was to do this to the best of their ability and to the highest possible standards in a caring environment, equitably, efficiently, with optimal accessibility, flexibility and using every human and financial resource available.

Staff we spoke with were knowledgeable about this and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The GP took an active leadership role for overseeing that the systems in place were consistently being used and were effective.

Practice staff were clear about what decisions they were required to make, know what they were responsible for as well as being clear about the limits of their authority. It was clear who was responsible for making specific decisions, especially decisions about the provision, safety and adequacy of the care provided at practice level and this was aligned to risk. The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impact on the quality of care.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at these policies and procedures and staff we spoke with understood how to access and use them. All policies and procedures we looked at had been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as health and safety risks. We saw that the risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

There was a clear leadership structure. For example the practice nurse was the lead for medicines management and for infection control and the GP was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the team. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including training, induction and recruitment, which were in place to support staff. We were shown the information that was available to all staff in the employee handbook. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. We also reviewed the induction policies that covered the GP, Locums, nursing and administration staff.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

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

The practice had gathered feedback from patients through comments and complaints received.

The practice did not have a patient participation group (PPG). However we saw evidence that the practice was promoting a PPG within the practice itself and also on their webpages.

Are services well-led?

Good

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

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain to develop through training and mentoring. We saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended on occasion.

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