Crossfell Health 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an inspection of Crossfell Health Centre practice on 22 April 2015 as part of our comprehensive programme of inspection of primary medical services. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led. It was rated as good for all of the population groups.

Our key findings were as follows:

- The practice was safe. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice is effective. Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice. According to the data from Quality and Outcomes Framework (QOF), an annual reward and incentive programme showing GP practice achievement results, outcomes for patients registered with this practice were average for England.
- The service is caring. Patients reported the positive view they had of the doctors and staff at the surgery. Practice staff knew their patients well. The service ensured patients received accessible, individual care, whilst respecting their needs and wishes. The QOF indicators showed that patients felt listened to and involved in decisions about their care and this was similar to other practices in the area.
- The service is responsive. The appointment system was guided by the needs and views of the patients. Urgent needs were addressed on the day and patients in general were able to see the GP of their choice. The service had positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- The service is well led. The practice had a clear vision and set of values which were understood by staff and made known to patients. There was a clear leadership

Summary of findings

structure in place. Quality and performance was monitored and risks were identified and managed. We found the practice focused on patient outcomes and the quality of care provided for their patients.

We saw several areas of outstanding practice including:

- To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointments, together with baby immunisations.
- The practice provided Musculo-Skeletal service, this helped minimise referrals to secondary (hospital) care. In addition care was provided closer to patients' homes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above the average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. Further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice similar to others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services, where these were identified. Some patients said they found it easy to make an appointment with a named GP. They found there was continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand. Evidence showed the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of patients 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 had 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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 patients who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us children 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 examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. There was a register of patients living in vulnerable circumstances including those with a learning disability. They received annual health checks and had received a follow-up appointment where necessary. Longer appointments were made available for patients with a learning disability.

The practice team regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had a number of in-house support services available for vulnerable patients. These patients were signposted to other support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns. They knew how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). All patients experiencing poor mental health had been offered an annual physical health check. There was evidence of collaborative working with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. There was evidence of advance care planning for patients with dementia.

Patients experiencing poor mental health could access support services within the practice as well as other voluntary organisations. There was 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.

Summary of findings

What people who use the service say

We received eight CQC patient comments cards where we found seven very positive comments about the practice and the staff. We saw comments about the excellent care patients and their families had received from all members of the clinical team. They said they were involved in all aspects of their care and the GPs and nurses explained everything to them. Some of the comments were from people who had been patients since the practice opened. There was one comment card which expressed whilst they were very happy with their care and treatment, they were however unhappy with the attitude at the front desk. The other negative point was about not being able to see their preferred doctor on days convenient to the patient.

The friends and family test report showed the patients who had completed the forms were more than happy with the care and treatment they received from the range of practice staff.

We spoke with seven patients, from different population groups, including a member of the Patient Participation Group. They all told us the staff were very helpful, respectful and supportive of their needs. They felt everyone communicated well with them; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were provided with a caring service.

However the recurring theme from all patients spoken with was the difficulty in accessing appointments on the same day. The telephone lines were reported to be very busy from 8.30am and when the patients got through, invariably all the appointments for that day had gone. The most recent patient survey confirmed that only 44% of patients found it easy to access appointments via the telephone compared with the CCG average of 88%.

The most recent patient survey positive results showed:

- 82% of respondents usually wait 15 minutes or less after their appointment time to be seen Compared with the local CCG average of 73%.
- 93% of respondents say the last GP they saw or spoke to was good at treating them with care and concern . Compared with the local CCG average of 86%.
- 92% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. Compared with the local CCG average of 87%.

Outstanding practice

- To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointment, together with baby immunisations.
- The practice provided Musculo-Skeletal service, this helped minimise referrals to secondary (hospital) care. A GP within the practice was highly skilled in this area; this meant care and treatment was provided closer to patients' homes.

Crossfell Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, a second CQC inspector and a Practice manager Specialist Professional Advisor.

Background to Crossfell Health Centre

The Crossfell Health Centre is located in a purpose built building at Berwick Hills in Middlesbrough.

The practice provides Personal Medical Services (PMS) under a contract with NHS England Middlesbrough, to the practice population of 10,500 patients. Our information shows fewer patients over the age of 85, which reflects the life expectancy within the area. The practice deprivation score is in the most deprived decile.

The practice has six GP partners (two male and four female) and one salaried GP. They are supported by two Nurse Practitioners (female) and two female practice nurses. Additionally there are two healthcare assistants providing clinical care. There is an administration team with specific roles identified and there is a practice manager.

The practice is open from 8.30 - 6pm, Monday – Friday and has extended opening hours on Saturday from 07.45 -1.15pm; these appointments are pre-bookable.

The practice has opted out of providing Out of Hours services to their patients. The practice uses Northern Doctors Urgent Care Ltd, for it's Out of hours cover from 6pm–8am each evening.

A wide range of services are available at the practice and these include: physiotherapy, vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease. There is a drug and alcohol worker based in the practice as well as a counsellor (Time to talk) who helps with issues such as bereavement and depression. The 'living well' project is also available at the practice. This can be either a drop in service or for patients who are referred by heir GP.

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.

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

Before visiting, we reviewed a range of information we held about the practice and asked other organisations, such as NHS England local area team and South Tees Clinical Commissioning Group (CCG), to share what they knew.

Detailed findings

We carried out an announced inspection visit on 22 April 2015. During our inspection we spoke with staff including two GPs, an advanced nurse practitioner, practice nurses and healthcare assistants, as well as the practice manager and administration/reception staff.

We spoke with seven patients, one of whom was a member of the Patient Participation Group (PPG). We observed how patients were being spoken with on the telephone and within the reception area. We also reviewed eight CQC comment cards where patients had shared their views and experiences of the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (QOF), patient survey results, the Patient Participation Group (PPG), clinical audits, professional development, and education and training.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the clinical, management meetings and with relevant staff. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of 22 significant events which had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken for example: Standard operating procedures were updated to ensure staff worked in a consistent way when supporting patients who were awaiting emergency ambulance transportation. Where patients had been affected by something, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff by email, on-line tasks or in meetings. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They confirmed alerts were discussed in clinical meetings to ensure they were aware of any relevant to their practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This was to ensure risks to children and young patients, who were looked after or on child protection plans, were known and reviewed. We were told there was frequent liaison with partner agencies such as, health visitors and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were mainly stored securely and were only accessible to authorised staff. There was a clear policy, for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. However, not all of these checks had been formally recorded. We found some medicines were not kept in locked cupboards, although patients did not have access to these areas. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings and noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The practice was supported by a pharmacist and a pharmacy technician. They ensured appropriate action was taken based on the results. We checked patient records which confirmed the procedure was being followed.

The nurses administered vaccines using directions which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their roles. They received updates in their specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were mainly handled in accordance with national guidance. They were tracked through the practice and kept securely. However we did not see a prescription security policy for all staff to refer to when ensuring prescription safety.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits for each of the last three years and any improvements identified for action were completed on time or had time bound actions. Minutes of practice meetings 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 measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff told us the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records, confirming regular checks were undertaken in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Good

Are services safe?

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. The vast majority of staff had been employed prior to the practice's registration with the CQC; the practice manager informed us all staff were to have their criminal records checked through DBS to follow best practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team. Arrangements were in place for changes to the flooring to be undertaken in treatment rooms.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and had learned from this appropriately.

Emergency medicines were available in 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 whether emergency medicines were within their expiry date and suitable for use. However we did not find any documented evidence of these checks. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this where clinicians were not available and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as diabetes, palliative care, gynaecology, minor surgery, orthopaedics and sports medicine. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers, which is within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

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. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

We were shown clinical audits which had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. They included a two cycle audit of improved preventative prescribing for patients with Ischaemic Heart Disease. Other examples included audits to confirm the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For

Good

Are services effective?

(for example, treatment is effective)

example, 84% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation for all clinical staff to undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. Where they continued to prescribe it, they outlined the reason why they decided this was necessary. The evidence we saw confirmed the GPs and Advanced Nurse Practitioners (ANP) had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. (Patients had individual care plans in place, named GPs and urgent access telephone numbers). The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

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. We noted a good skill mix among the doctors who all had additional diplomas in areas such as orthopaedics, surgery (FRCS), palliative care, family planning and reproductive medicine. All GPs were up to date with their annual continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example dementia training was identified for the ANP. We saw that this had been arranged.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles e.g. seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were able to demonstrate they had appropriate training. All nurses had their 'fit for practise' reviewed each year via the Nursing and Midwifery Council (NMC) registration web site.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues which arose from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service to follow up patients on discharge from hospital and had a process in place. (These services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the procedure for actioning hospital communications was working well in this respect. The practice undertook an annual audit of follow-ups to ensure inappropriate follow-ups were documented and that none were missed.

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

Information sharing

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

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational this year. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

All clinical staff demonstrated a clear understanding of Gillick competencies. (Used to help assess whether a child had the maturity to make decisions about their care and treatment and to understand the implications of these decisions).

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

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs

Good

Are services effective?

(for example, treatment is effective)

Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

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

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

The practice had numerous ways of identifying patients who needed additional support, and they were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Practice records showed 96% had received a check up in the last 12 months. The practice had also identified the smoking status of 96% of patients over the age of 16 and actively offered smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'in the middle' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses; with 93% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received eight completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but had no common themes. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection.

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. They told us these would be investigated and any learning identified would be shared with staff. We were shown an example of a report on a recent incident which showed appropriate actions had been taken. There was evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations. Some told us of their recent training relating to managing aggressive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were similar to the national average. The results from the practice's own satisfaction survey showed that 76% of patients said they were sufficiently involved in making decisions about their care.

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

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 85% of respondents to the Patient Participant Group survey said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the 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 if families had suffered a bereavement, their 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. Patients we spoke with 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 patient'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 in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included the GP electronic system for alerting patients to their appointed room was now in larger font, to help patients who had disabilities.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had 22 appointments available on Saturday mornings; for patients who work and for those patients who required a carer to help them access the service.

The practice had access to online and telephone translation services and a GP who spoke other languages.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises were purpose built and met the needs of patient with disabilities. The waiting room and the treatment and consulting rooms could accommodate wheelchairs which helped to maintain patients' independence. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of 98.9% English speaking patients though it could cater for other languages through translation services.

Access to the service

The practice is open from 8.30 - 6pm, Monday – Friday. Last appointments are mainly 5.10 pm apart from on Wednesday when the last appointment is 5.30pm. There are extended opening hours on Saturday from 07.45 -1.15pm; where appointments are pre-bookable.

Comprehensive information was available to patients about appointments 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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Patients who resided in care homes were visited when required.

Patients were generally satisfied with the appointments system according to the recent patient survey. However we were told getting an appointment with a named GP was always difficult. Patients confirmed they could see a doctor on the same day in an emergency. They told us they would queue outside the surgery before 8.30 am because all appointments were taken by 9am. The practice had conducted audits to ascertain the demands and needs of the practice population for GP appointments. They had offered telephone triage which only increased demand and did not meet needs. They had appointed more staff and recently increased the salaried GPs' sessions. 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. For example, one patient we spoke with told us how they had rung with an urgent health problem and were seen within 15 minutes and transferred to hospital immediately.

Listening and learning from concerns and complaints

Good

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 was displayed in the waiting room, on the website and in the practice 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 33 complaints received in the last 12 months and found these were satisfactorily handled. They were dealt with in a timely way. They used a good template and we found evidence of actions taken. We found one concern (taken via the telephone) had not been typed nor had this been followed up with a letter confirming the conversation. The practice manager assured us this would be rectified immediately.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice vision and values included putting patients first and listening. It included the importance of team work and how they drove forward continuous improvements and adaptations.

We spoke with eight members of staff and they all knew and understood the vision and values 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 on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

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

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw that hypnotics prescribing had reduced by eight per cent in the last year.

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

Leadership, openness and transparency

We saw from minutes, team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example whistle blowing, recruitment and safeguarding children and vulnerable adults which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through friends and family feedback, comments, complaints and surveys. We looked at the results of the annual patient survey and found action points had been determined to encourage increased awareness of the health promotion disease prevention clinics available to patients.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups; patients with Long Term Conditions and those recently retired. The PPG had carried out surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals, 360 degree feedback and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training during their appraisal and this was now in place. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Are services well-led?

Good

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

Staff told us that 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. We saw an induction programme was completed by new staff and all staff had completed mandatory training. This included: fire safety awareness, information governance, safeguarding vulnerable adults and children and equality and diversity. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. We saw the practice held a record of all training undertaken and details of when refresher training would be required.

Staff told us the training they received helped to improve outcomes for the patients. The staff we spoke with told us they felt supported to complete training and could request any additional training which would benefit their role.

The practice used information such as the Quality Outcome Framework (QOF) and patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.