Dr S W Redfearn & Partners

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

This is the report of findings from our inspection of Dr Redfearn and Partners.

We undertook a comprehensive inspection on 12 May 2015. We reviewed CQC comment cards completed by patients and spoke with patients, staff and the practice management team.

Overall, the practice was rated as Good. A safe, caring, effective, responsive and well- led service was provided that met the needs of the population it served.

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

- There were systems in place to protect patients from avoidable harm. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered in consideration with best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients were very positive about the care they received from the practice. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice planned its services to meet the differing needs of patients. The recently upgraded telephone system improved access to the appointment system. The practice encouraged patients to give their views about access to the services and made changes as a consequence.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

There was an area of practice where the provider needs to make improvements.

The provider should:

- Record multi-disciplinary meetings to demonstrate monitoring arrangements and support for palliative care patients and identified vulnerable patients.

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. There were systems in place to protect patients from avoidable harm. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. 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. The practice monitored its performance data and had systems in place to improve outcomes for patients. Patient's needs were assessed and care was planned and delivered in line with best practice and national guidance. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any 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 partners however the practice should record these meetings to demonstrate monitoring arrangements and support for palliative care patients.

Are services caring?

Good

The practice is rated as good for caring. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy. Patients were provided with support to enable them to cope emotionally with care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). Patients were usually provided with their own named GP providing continuity of care, with urgent appointments available the same day. Access to the service was monitored to ensure it met the needs

Summary of findings

of patients. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for providing a well-led service. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a 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. The practice did not have a high population of elderly patients in comparison to national data within England. The practice was knowledgeable about the number and health needs of older patients using the service. They had recently employed an 'Elderly Care Nurse' to provide a holistic approach to help meet the health and social care needs of their over 75 year old patients and their 2% of patients assessed as at risk. These comprehensive assessments provided longer appointments and home visits if needed. The practice had identified all patients at risk of unplanned hospital admissions and a care plan had been developed to review them on a regular basis including any unplanned hospital admission. The practice met with the community matron and the district nursing team on a regular basis to provide support and access specialist help when needed. The practice had a Carers register. Patients who are carers were coded on the system and given priority for appointments. The practice had a "Carers Champion" whose role was to be the point of contact for carers and in respect of sign posting them to organisations that were able to support carers.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment and screening programmes. They operated a call and recall system that enabled all co morbidities to be reviewed simultaneously. Clinical staff had lead roles in chronic disease management and had a system in place to make sure no patient missed their regular reviews for long term conditions. They also provided additional specialities services such as in-house ECG and spirometer service. Patients had a named GP and named GPs carried out any home visits to their own patients to ensure continuity of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised.

Summary of findings

Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. We received positive feedback from mothers with children regarding their care and treatment at the practice. They told us they were confident with the care provided to them and received same day appointments when needed. The practice had a policy of always offering a same day urgent appointment. The practice had a good uptake rate for child immunisations and they offered a family planning service including IUD fitting. The practice took part in the piloting of the new Warrington Paediatric Acute Response Team (PART) which is now a commissioned service across the town to help reduce admissions to hospital particularly with relation to children with gastro problems/ conditions that required monitoring. This monitoring is undertaken in conjunction with the practice and the PART team.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The practice was open Monday to Friday 8am-6.30pm. The practice offered pre- bookable appointments, on the day appointments for urgent medical conditions, home visits and telephone consultations. The practice was proactive in offering online services such as bookable appointments, on line prescription requests and access to patients own medical notes. Patients unable to visit the practice in core hours were able to book later in the day/weekend appointments at Warrington Health Plus Extended Access Service. The practice monitored patient satisfaction with access to the service through patient feedback. Following patient feedback they recently introduced a new telephone system which had helped better access and management of patient calls.

The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation, alcohol consumption and contraceptive services. They offered an in house physiotherapy service that provided rapid access to patients with musculoskeletal problems to try to facilitate an early return to work. They also operated a travel vaccination clinic.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, a register was maintained of patients with a learning disability and annual health care reviews were provided to these patients. The

Summary of findings

practice provided longer appointments for vulnerable patients. All Staff were trained and knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received guidance in this.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients with mental health problems were provided with a number of services based at the practice and included an outpatient psychiatric clinic with visiting consultants in psychiatry; Warrington Improving Access to Psychological Therapies Service (IAPT service); a Pathways community alcohol worker and a depot injection clinic. These services and communication between these teams helped provide better accessibility for patients and helped to reduce DNA rates.

Summary of findings

What people who use the service say

We looked at 24 CQC comment cards that patients had completed prior to the inspection and spoke with 14 patients. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, younger people and those with children. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity, staff were caring, supportive and helpful. Staff knew patients individually and took time to listen to them. Patients told us that doctors were good and they felt safe in their care, they told us they had enough time to discuss things fully with the GPs, treatments were explained, they felt listened to, were involved in decisions about their care and they felt there had been improvements in the phone system and access to booking appointments. Out of 24 comment cards received, four patient comments indicated that improvements were needed to the telephone system as they had experienced problems getting through to the practice. Minuted meetings, records and discussions with representatives from the Patient Participation Group (PPG) indicated that an action plan had been put in place to address this issue with the recent implementation of the new telephone system.

The National GP Patient Survey in March 2014 found that 83.3% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 87.6% of patients described the overall experience of their GP surgery as fairly good or very good. Eighty six per cent (86.6%) of practice respondents said the last time they saw or spoke to a GP, the GP was good or very good at treating them with care or concern and 84.2% said the last time they saw or spoke to a nurse the nurse was good or very good at treating them with care or concern. This data demonstrated the practice was about average when compared to other practices nationally.

The National GP Patient Survey in March 2014 found that 71.7% of patients were very satisfied or fairly satisfied with opening hours. Sixty per cent rated their ability to get through on the telephone easy or very easy. These results were about average when compared to other practices nationally.

The practice reviewed all patient information and feedback from 2014/15 with their PPG and included the work they had collated around their Productive General Practice initiative. (Productive general practice is a support programme produced by the National Institute of Health that helps support practices in creating capability and capacity. This review produced a detailed action plan covering main themes such as telephone access; surgery waiting times; out of hour's appointments; prescribing and referrals. The plan detailed actions taken and continued review in these areas. One action resulting from the Productive practice exercise was the development of a patient information leaflet to give to patients to inform them of their referral and what to expect. This was initially shared with the PPG for their review and comments. The information leaflet is now given to patients at the point of referral and available on the practice's website.

Areas for improvement

Action the service SHOULD take to improve

- Record multi-disciplinary meetings to demonstrate monitoring arrangements and support for palliative care patients and identified vulnerable patients.

Dr S W Redfearn & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a practice manager, specialist advisors and a second CQC inspector.

Background to Dr S W Redfearn & Partners

Dr S W Redfearn & Partners is based in Birchwood, Warrington. The practice treats patients of all ages and provides a range of medical services. The staff team includes four male GP partners; two female salaried GPs; four senior nurses; two healthcare assistants; a practice manager; an assistant practice manager; with four secretaries; three reception staff and nine administration staff. The practice is a 'training practice'. This means hospital doctors wanting to enter general practice spend time at the practice in order to gain the experience they need to become family doctors. The practice has F2 and GP registrars working for them as part of their training and development in general practice. The practice is in the process of recruiting an additional salaried GP.

The practice is open Monday to Friday from 8.00 am to 6.30 pm. Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre bookable consultations, same day (advanced access) appointments and home visits to patients who are housebound or too ill to attend the practice. The practice closes one afternoon per month for staff training. When the practice is closed patients are offered the additional choice of evening or weekend non-urgent appointments. These appointments are available to patients across Warrington as part of the Warrington Health Plus Extended Access Service. (This service was established 2014 by the GP Federation through the 'Prime Ministers Challenge Fund' (PMCF). The appointments are available at Bath Street Health and Wellbeing Centre between the hours of 6pm to 8pm weekdays and 8am to 8pm on Saturdays and Sundays. Emergency Out-of-Hours contact for urgent medical assistance is via 111.

The practice is part of Warrington Clinical Commissioning Group. It is responsible for providing primary care services to approximately 11,375 patients.

The practice has a Personal Medical Contract (PMS).

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.

Detailed findings

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 12th May 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We sought views from patients; held a meeting with members of the patient participation group; looked at survey results and reviewed comment cards left for us on the day of our inspection. We spoke with the practice manager and deputy manager; registered manager; GPs; senior nurse's; administrative staff and reception staff on duty.

Good

Are services safe?

Our findings

Safe track record

NHS Warrington Clinical Commissioning Group and NHS England reported no concerns to CQC about the safety of the service. The practice used a range of information to identify risks and improve patient safety. For example, they reviewed incidents and national patient safety alerts as well as comments and complaints received from patients at weekly staff meetings. We reviewed safety records and minutes of meetings where these were discussed for the last 12 months. A plan of action had been formulated following analysis of the incidents and information was disseminated to all staff. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents. For example staff relayed a previous incident regarding another patient's details being inadvertently attached to another patient's requested information. Staff relayed their lessons learnt and were confident the extra checks introduced secured patient confidentiality and reduced any further errors occurring.

Learning and improvement from safety incidents

Significant events was a standard agenda item discussed at dedicated staff meetings. These meetings took place every two to three months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with all staff. Staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so and in an open, no blame culture. The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The GP's described a recent alert from MHRA in regard to the medication, Domperidone. From this alert they were able to arrange a review of at least 30 patients to assess their needs.

We tracked a sample of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of an action taken as a result of a medication error. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding procedures for both children and vulnerable adults. These policies provided staff with information about identifying, reporting and dealing with suspected abuse. Training records and staff we spoke with, including two GPs who took the lead for safeguarding confirmed they had received training in safeguarding at a level appropriate to their role. Medical, nursing and administrative staff demonstrated good knowledge and understanding of safeguarding and their responsibilities in reporting any safeguarding concerns.

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. Dedicated staff were responsible for reviewing the register for vulnerable children and in highlighting to the GPs any admissions to hospital that those children had received. Regular liaison took place with the health visitor to discuss any children who were at risk of abuse. Staff documented these discussions in patient's computerised medical records. However separate minutes had not been kept of these meetings. The lack of recording of these meetings could not demonstrate that the practice had taken a general overview of their vulnerable children's list with multi-disciplinary staff.

The practice had a chaperone policy which was displayed in the reception area. Clinical staff had a Disclosure and Barring Service (DBS) check and acted as chaperones. 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. After the inspection the practice provided evidence that staff had

completed chaperone training.

Medicines management

There were systems in place for medicine management. The GPs re-authorised medication for patients on an annual basis or more frequently if necessary. A clinical system was in place for clinicians to highlight patients requiring medication reviews. GPs worked with pharmacy support from the Clinical Commissioning Group (CCG) to review prescribing trends and medication audits and the practice had an identified medicines lead.

The practice had three fridges for the storage of vaccines. The nurse practitioner took responsibility for the stock controls and fridge temperatures. We looked at a sample of

vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use. Medications were stored securely and only accessible to authorised staff. Staff were clear in describing safe practices following their policy guidance in the storage of medicines and checking safe temperatures with storage of medications and vaccines.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the treatment room area. The nurse practitioner had overall responsibility for ensuring emergency medicines were in date and carried out recorded checks. All the emergency medicines were in date.

Prescriptions were managed electronically with any paper prescriptions being securely held. Patients could order repeat prescriptions on line, the practice had 1400 patients registered for this service. Administrative staff that we spoke with were positive about a recent initiative with the dedicated use of an office for managing prescriptions. This occurred following their feedback and suggestions to the GPs to improve processes and reduce the risk of errors. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked and signed for through the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning schedules showed effective management of the cleaning programme throughout the practice. Treatment rooms had hand washing facilities and personal protective equipment (such as gloves) was available. The practice did not use any instruments which required decontamination between patients. Clinical waste disposal contracts and sharps boxes were in place. Staff knew what to do in the event of a sharps injury and appropriate guidance was available.

The nurse practitioner was the designated clinical lead for infection control. There was an infection control policy in place and staff had received up to date training. The practice took part in external audits with the local community infection control team and acted on any issues identified. The practice had recently carried out their own infection control audit. This audit showed that the premises where 99% compliant with infection control.

At inspection we noted there had been no certified checks for Legionella however this evidence was provided after the inspection visit. The practice manager had taken appropriate actions in regard to their risk assessment of Legionella (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.) They had arranged for a contractor to maintain the water systems over a 24 month period. This identified actions that needed to be taken to

ensure the safety of the water supply to the practice.

Equipment

Staff we spoke with told us they had appropriate equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and safely maintained. We saw equipment maintenance logs and updated portable electrical equipment tests. We saw evidence of calibration covering 72 items of relevant equipment: for example weighing scales; ECG machine; vaccine refrigerators; thermometers; spirometers; medical scales; cautery machine; spirometers and blood pressure measuring devices. The equipment register was managed by the practice manager to ensure all equipment was safely maintained.

Staffing and recruitment

We looked at the recruitment files for three clinical staff and one newly recruited receptionist. We found that appropriate checks had been carried out to show the applicants were suitable for their posts. Records contained safe checks. For example: proof of identification; references; qualifications; registration with the appropriate professional body; professional indemnity insurance and criminal records checks through the Disclosure and Barring Service (DBS) for staff roles needing these checks to be in place. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were well managed and in line with planned staffing requirements needed for the practice and staff

Good

Are services safe?

availability was continually discussed at their weekly appointments meetings. Although there was a vacancy for a GP, the practice rarely used locum services as they usually covered for each other.

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. One health care assistant was being supported in training for her NVQ 3 which will enable her to extend her clinical role and support for the practice.

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 in house and contractual 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 were two identified health and safety representative.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about their 'code red' emergency procedures. They described how they had previously responded to this emergency call to assist a patient who had collapsed and that all staff were instructed to attend until directed otherwise. There were emergency processes in place for patients with long term conditions and clinical staff had access to emergency drugs suitable to their specific medical emergency such as unstable diabetes.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage major incidents and emergencies. Records showed that all staff had received training in basic life support. Emergency medicines, oxygen and equipment were available including access to an automated external defibrillator (used to attempt

to restart a person's heart in an emergency). Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All staff knew the location of this equipment and emergency medicines and records confirmed that they were regularly checked were in date and fit for use.

An up to date business continuity plan was in place to deal with a range of emergencies that may have impacted on the daily operation of the practice. A recent power failure at the practice prompted the use of this plan and staff and records showed how the power failure was effectively managed to minimise any risks to patients or any of the drugs stored in refrigerators.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed they had updated checks on the fire alarm, emergency lighting and fire fighting equipment to ensure they were operating safely.

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. Clinical staff told us how they accessed best practice guidelines to inform their practice. GPs and nursing staff attended regular training and educational events and they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. They specifically discussed NICE updates at meetings which provided them an opportunity to review complex patient needs and kept everyone up to date with best practice guidelines. The practice took part in the enhanced service for avoiding unplanned admissions scheme. The clinicians ensured care plans were in place and regularly reviewed. The GPs told us they lead in specialist clinical areas such as diabetes, muscular skeletal and respiratory diseases and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

We saw data from Warrington CCG of the practice's performance dashboard. This showed the practice was meeting the target threshold across the indicators, for example, for enhancing quality of life for patients with long term conditions. Data from the local CCG of the practice's performance for antibiotic prescribing was comparable to similar practices.

National data showed that the practice was in line with referral rates to secondary and other community care services.

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, reviewing hospital admissions, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical cycles. The practice showed us six clinical audits that had been undertaken in the last 18 months. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

One of these completed audits showed where the practice was able to demonstrate the changes resulting since the initial audit. The practice used the 'Royal College of General Practitioners'

(RCGP) audit tool and significant event audit to collect a comprehensive dataset and case study examples on new cancer diagnoses in the practice. They aimed to identify areas for improvements and to monitor the impact of service improvements addressing the care pathway to cancer diagnosis in the practice and within Warrington. The second cycle showed the practice were making good use of the two week wait criteria (Patients first seen within 14 days of GP urgent suspected cancer referral.) GPs maintained records showing how they had evaluated the service and documented the success of any changes. The practice had recently submitted a significant event to the cancer care network about a patient for their external review and were waiting for their comments and recommendations to help influence their practice.

Quality and Outcomes Framework (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 the most recent results for 2014/2015 showed improvements in the scores for diabetic patients receiving foot examinations as part of their diabetic assessments and check-ups. Seventy nine per cent of patients had received a foot examination in the last 12 months which was within national data sets between 50-90%. They had initiated insulin checks to appropriate patients with Type 2 Diabetes reducing the need for this group of patients to attend secondary care clinics. In the last 12 months the practice had commenced five patients on insulin. The practice met all the minimum standards for QOF in diabetes and chronic obstructive pulmonary disease. The QOF data for 2014/15 was confirmed during the inspection.

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

Good

Are services effective?

(for example, treatment is effective)

An appraisal policy was in place. Staff were offered annual appraisals to review performance and identify development needs for the coming year. We spoke to reception/administrative staff and nurses who told us the practice was supportive of their learning and development needs. They said they had received an appraisal in the last 12 months and that a personal development plan had been drawn up as a result which identified any training needed. All GPs were up to date with their yearly continuing professional development requirements. (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). Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month for in-house developmental meetings.

We reviewed staff training records and saw that all staff were up to date with training such as: basic life support; fire safety; health and safety; information governance and equality and diversity. The nurse practitioners attended local practice nurse forums and attended a variety of external training events such as: Paediatric Asthma; COPD Management; Yellow Fever Update Training and Contraception and GUM Update. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

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. It 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 mainly operated on a paperless basis with a lot of correspondence managed via their computer system. However any incoming letters from hospitals were scanned onto patient notes and passed onto GPs for action and dealt with on a daily basis. The practice used the patient choose and book system for referrals to hospitals and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral.

The practice liaised with other healthcare professionals such as the Community Matron and with the multi-disciplinary health care team to discuss patients on their palliative care register.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. 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.

Services throughout Warrington used the same electronic patient record system and out of hours services would access patient's notes as needed. The practice planned and liaised with the out of hours provider for Warrington regarding any special needs for a patient; for example forms were sent regarding end of life care arrangements for patients who may require assistance during the weekend. Patients were able to register with their online facility to access their own summary case notes which provided a transparent process to enable patients to access at any time.

The practice had several systems in place to ensure good communications between staff. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues especially when they were on leave during team meetings.

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions and had included capacity checks in their assessment records and care plans. Clinical staff demonstrated a clear

Good

Are services effective?

(for example, treatment is effective)

understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice had a consent policy and staff were clear in regard to obtaining signed consent forms for their minor surgery clinic.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify where improvements were needed and to take action on. Quality and Outcomes Framework (QOF) information showed

the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example: in providing flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions. Immunisation rates were in line with the averages for the area for example the percentage of infants receiving their first vaccinations was 96.2% which was comparable with the local average of 96.9%.

New patients registering with the practice completed a health questionnaire and were given an assessment by the health care assistant. Any concerns raised were referred to the GP and transient groups such as travellers were always seen by the GPs. 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 identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange regular health reviews. Patients told us they received regular updates and felt supported and monitored with their health conditions. The practice also kept registers of vulnerable patients such as those with learning disabilities and used these to plan their annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was an area available if patients wished to discuss something with them away from the reception area. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments.

Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients we spoke with and CQC comment cards received told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in March 2014. It found that 87.6% of patients described the overall experience of their GP surgery as fairly good or very good. Eighty nine per cent (89.6%) of practice respondents said the last time they saw or spoke to a GP, the GP was good or very good at treating them with care or concern and 84.2% said the last time they saw or spoke to a nurse the nurse was good or very good at treating them with care or concern. This data demonstrated the practice was about average when compared to other practices nationally.

The National GP Patient Survey in March 2014 found that 71.7% of patients were very satisfied or

fairly satisfied with opening hours.60.4% rated their ability to get through on the telephone easy or very easy. These results were about average when compared to other practices nationally. However following these results the practice have installed a new telephone system to help them improve access for patients when trying to contact them. Positive comments were made by patients about the new system with some patients advising they had only phoned an hour before and were assisted with an appointment the same day.

Care planning and involvement in decisions about care and treatment

The National Patient Survey in March 2014 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, it found that that 83.3% of practice respondents said the GPs were good or very good at involving them in 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.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme and care plans were shared with patients to ensure there care plans were regularly reviewed and inclusive of their needs.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs.

Patients and CQC comment cards told us they had received help to access support services to help them manage their treatment and care when it had been needed. They told us that all staff responded compassionately when they needed help and provided support when required. The practice had a Carers register. Patients who were carers were coded on the system and given priority for appointments. The practice had a "Carers Champion" whose role involved being the point of contact for carers and in respect of sign posting them to carer's organisation.

There was supporting information to help patients who were carers in the waiting room. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The practice engaged regularly with NHS Warrington Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had an active Patient Participation Group (PPG). The purpose of the Patient Participation Group was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed how the Patient Participation Group had been consulted over the type of questions to include in the patients survey. Records and a discussion with representatives from the Patient Participation Group indicated how they had worked with the practice to make improvements to access the service and were looking at further developments of this group to encourage more members. The PPG meetings were minuted and also available on the practices website. This access to information offered further updates and openness in their discussions with the practice staff in regard their feedback and involvement.

Tackling inequity and promoting equality

The building had appropriate access for disabled people and was all on single level and purpose built. A disability access assessment had been carried out. 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.

The practice had a small proportion of minority groups for whom English was not their first language. Staff were knowledgeable about interpreter services for patients and information about this service was available.

The practice had an equal opportunities policy which was available to all staff via their computer system. The practice provided equality and diversity training to all staff, training records and staff we spoke with confirmed they had received updated training and were aware of the needs of their patients groups. Staff told us they always treated any transient groups who presented at the practice regardless of no fixed home address.

Access to the service

The practice was open between 8.00am to 6.30pm Monday to Friday. Patients could book appointments in person, on-line or via the telephone. The practice provided a mixture of appointments such as: telephone consultations, pre bookable consultations, same day/emergency appointments and home visits to patients who were housebound or too ill to attend the practice. The practice closed one afternoon per month for staff training. Patients unable to visit the practice in core hours were able to book later in the day/weekend appointments at Warrington Health Plus Extended Access Service. This was available during 6.30 p.m.-8.00 p.m. and Saturday and Sunday 8.00 a.m.-8.00 p.m.

Members of the PPG told us that improvements had been made with access due to the recent installation of the new telephone system and that it seemed to be working well.

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available in the waiting room and in the practice leaflet. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint. The practice kept a complaints log and recorded verbal as well as written complaints. The practice reviewed the complaints received on an annual basis to identify any trends in issues which would require any improvements. Learning points from complaints were discussed at staff meetings.

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 and its statement of purpose sets these out as:-

"The practice has a focus on training and works with other community services to provide holistic care. The practice aims to provide care that is patient-centred and tailored to the individual and benefits from a doctor/patient relationship built up over time by the provision of continuity of care. Patients will be involved in decisions about their care planning and regular satisfaction surveys will be conducted and the results used to further improve the service. It aims to actively promote health and wellbeing with appropriate and effective intervention. The practice is committed to ensuring that patients and their carer's are treated with respect and that there is a managed healthcare environment which minimises the risk of infection to patients, staff and carers. The practice endeavours to make efficient use of health care resources through co-ordinating care, reflecting on performance, working with other professionals in the primary care setting and by managing the interface with secondary care, but taking an advocacy role for the patient when it is needed.'

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the centre of everything they did. They felt that patients should be involved in all decisions about their care and that patient safety was also paramount. Comments we received from patients and members of the PPG were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and in a paper format. We looked at a sample of policies and procedures and found that they were up to date and regularly reviewed. The policies included: Health and safety; Consent; and Infection control. All of the policies were regularly reviewed and in date and staff we spoke with were aware of their contents.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The GPs spoken with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GPs showed improvements had been made to the operation of the service and to patient care as a result of the audits undertaken. The practice had a lead GP for clinical governance. Regular governance meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice nurse told us about a local peer review system they took part in with neighbouring GP practice nurses called, 'Practice makes perfect.' The practice nurse told us that through these groups they had the opportunity to develop their own skills and identify areas for improvement.

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. All staff we spoke with were able to describe how changes had been made to the practice as a result of reviewing significant events.

Leadership, openness and transparency

Although there was no written protocol to describe the leadership structure, staff described the leadership structure in place and the lines of accountability. Staff had specific roles within the practice, for example, safeguarding and infection control and clinical staff took the lead for different clinical areas, for example; diabetes; asthma and sexual health. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

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 or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed. Staff told us they could raise concerns and felt they were listened to.

We reviewed a number of human resource policies and procedures that were available for staff to refer to, for example: equality and whistleblowing. Staff we spoke with were aware of what to do if they had to raise any concerns.

Are services well-led?

Good

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

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

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys and through the complaint procedure. The practice staff and information available on the practice website encouraged patients to complete the Friends and Family Test as a method of gaining patients feedback. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014.

The practice had a Patient Participation Group. The purpose of the Patient Participation Group was to meet with practice staff to review the services provided and help determine the commissioning of future services in the neighbourhood. Surveys sent by the practice were discussed and agreed with the Patient Participation Group and an action plan devised with them. We met with representatives of the Patient Participation Group who told us they met four times a year and also communicated via email. They told us that a number of improvements had been made to the practice as a result of their involvement, such as the revision of questions for patient surveys. They said they felt they were listened to and that their opinions mattered. They discussed forthcoming plans to canvas patient's comments and opinions about car parking facilities and felt supported by the practice in this approach.

Staff told us they felt able to give their views at practice meetings. Staff told us they could raise concerns and felt they were listened to.

The practice had engaged with the 'Productive General Practice Programme' to review their back office systems. This helped them to listen to staff opinions and to introduce improvements to their day to day working in particular the management of prescriptions. This initiative helped the practice to effectively communicate with their staff and engage with them to develop a fundamental re design of their approach to this job role.

Management lead through learning and improvement

Clinical and non-clinical staff told us they worked well as a team and had good access to support

from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. Staff told us the practice was supportive of their learning and development needs and that they felt well supported in their roles. Staff were offered annual appraisals to review performance and identify development needs for the coming year. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The practice was a GP training practice. This meant hospital doctors wanting to enter general practice spent time at the practice in order to gain the experience they need to become family doctors. The practice had an F2 and GP registrars working for them as part of their training and development in general practice. The practice had lead GP's responsible for their training and supervision while at working at the practice.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures.