

Launceston Close Surgery

Quality Report

9-10 Launceston Close
Winsford
Cheshire
CW7 1LY

Tel: 01606 544744

Website: www.launcestonclosesurgery.nhs.uk

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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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Launceston Close Surgery. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to meet the needs of all population groups of patients. We found improvements were needed to the records of staff recruitment to demonstrate the suitability of staff for their roles.

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

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and equipment. However, improvements

were needed to the recruitment of staff as the recruitment records did not demonstrate that all necessary checks were undertaken to demonstrate suitability for their roles.

- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff worked together and with other services to promote patient care. The practice monitored the services it provided and made changes as required.
- Feedback from patients showed they were overall very happy with the care given by all staff. They felt listened to, treated with dignity and respect and involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The practice encouraged patients to give their views about the services offered and made changes as a consequence.

Summary of findings

- Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

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

Importantly, the provider must:

- Take action to ensure its recruitment policy, procedures and arrangements are improved to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

The provider should:

- Ensure that clinical staff receive an appraisal and formal supervision from an appropriately qualified member of staff.
- Record all risk assessments so that they can be reviewed to ensure they remain effective.
- Review the systems in place to ensure scanning of patients records is carried out without unnecessary delay.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe. There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk. There were appropriate systems in place to protect patients from the risks associated with medicines and infection control. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. However, improvements were needed to the recruitment of staff as the recruitment records did not demonstrate that all necessary checks were undertaken to verify suitability for their roles. Risk assessments should also be recorded so that they can be reviewed to ensure they remain effective.

Requires improvement



Are services effective?

The practice is rated as good for effective. Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were provided with the training needed to carry out their roles and they were appropriately supported. We found that improvements should be made to the process for support and evaluating the performance of the practice nurse. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice worked with health and social care services to promote patient care.

Good



Are services caring?

The practice is rated as good for caring. Patients were overall 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 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.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice planned its services to meet the differing needs of patients. They monitored the

Good



Summary of findings

service to identify patient needs and service improvements that needed to be prioritised. Access to the service was monitored to ensure it met the needs of patients. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

Are services well-led?

The practice is rated as good for well led. Quality and performance were monitored, risks were identified and managed. Staff told us they felt the practice was well managed, that they could raise concerns and felt they were listened to. The practice had systems to seek and act upon feedback from patients. Improvements had been made to the service as a result of listening to patients.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service and used this information to plan reviews of health care. AGP was linked to a care home in the area. The GP visited this home on a weekly basis and could be contacted by telephone for advice and support. Each care home patient had a care plan and an annual review of these patients was undertaken. This service promoted continuity of patient care, effective communication and assisted in identifying ill health more easily. The practice ensured each person who was over the age of 75 had a named GP. The practice worked with other agencies and health providers to provide support and access specialist help when needed. The practice had identified patients at risk of unplanned hospital admissions and a care plan had been developed to support them. Patients discharged from hospital received a follow up consultation.

Good



People with long term conditions

The practice is rated as good for the population group 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, screening programmes and vaccination programmes. The practice had a system in place to ensure patients received reviews for long term conditions and to follow up unplanned hospital admissions in a timely manner. The practice kept a record of patients needing palliative care. Palliative care meetings were held regularly to ensure the needs of patients were being appropriately addressed.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Child health surveillance and immunisation clinics were provided. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Staff were knowledgeable about child protection and one of the GPs took the lead for safeguarding. Alerts were placed onto the patient's electronic record when safeguarding concerns were raised. Liaison took place with the health visiting service to discuss any children

Good



Summary of findings

who were at risk of abuse and advice was taken from the Vale Royal Clinical Commissioning Group lead for safeguarding where necessary. Children were prioritised for urgent appointments to ensure their safety and wellbeing. Antenatal and family planning services were provided. Sexual health advice was provided and patients were sign posted to other services as needed.

Working age people (including those recently retired and students)

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 from 08.00 to 18.00. An evening surgery was provided on Tuesdays 18.30 to 21.00 which offered routine pre-bookable appointments with the practice nurse. Patients could book appointments in person, on-line or via the telephone. The practice provided telephone consultations (including early morning) and pre bookable consultations up to two weeks in advance. This provided flexibility to working patients and those in full time education. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the population group 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. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this. The practice had a record of carers and used this information to discuss any support needed and to refer carers on to other services if necessary. A member of the Carers Trust spent an afternoon at the practice each month advertising the services available for carers in the local community.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

Good



Summary of findings

The practice provided a service for the early diagnosis of patients with dementia. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may benefit from counselling services for bereavement.

Summary of findings

What people who use the service say

We looked at 39 CQC comment cards that patients had completed prior to the inspection. Patients were overall 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. The comments indicated that patients were generally satisfied with access to the service.

We spoke with six patients who were very positive about the services provided. They told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to. They all said they were able to get an appointment when one was needed and that reception staff were friendly and helpful. They said that phone access to the practice was satisfactory, they were satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

The National GP Patient Survey published in January 2015 found that 82% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Eighty four per cent said the GP was good at giving them enough time and 89% said the GP was good at listening to them. These responses were about average when compared to other practices locally and nationally.

Eighty five per cent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern and 84% said the nurse was good at listening to them. These responses were slightly higher than average when compared to other practices locally and nationally.

Eighty per cent of practice respondents said the GPs were good or very good at involving them in decisions about their care and 71% felt the nurses were good or very good at involving them in decisions about their care. These responses were above average when compared to other practices locally and nationally.

Eighty three per cent of patients were very satisfied or fairly satisfied with opening hours. Eighty per cent said they didn't have to wait too long to be seen and 77% said the GP opening times were convenient. These responses were higher than average when compared to other practices locally and nationally. Seventy per cent rated their ability to get through on the telephone as easy or very easy and 74% described their experience of making an appointment as good. Eighty six per cent said they would recommend this practice to someone knew to the area. These responses were about average when compared to other practices nationally and higher than average when compared to other practices locally.

Areas for improvement

Action the service **MUST** take to improve

- Take action to ensure its recruitment policy, procedures and arrangements are improved to ensure necessary employment checks are in place for all staff and the required information in respect of workers is held.

Action the service **SHOULD** take to improve

- Ensure that clinical staff receive an appraisal and formal supervision from an appropriately qualified member of staff.
- Record all risk assessments so that they can be reviewed to ensure they remain effective.
- Review the systems in place to ensure scanning of patients records is carried out without unnecessary delay.

Launceston Close Surgery

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.

Background to Launceston Close Surgery

Launceston Close Surgery is based in Winsford in Cheshire. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, a regular locum GP, a practice manager, a practice nurse, a healthcare assistant and reception and administrative staff.

The practice is open Monday to Friday from 08.00 to 18.00. An evening surgery is provided on Tuesdays 18.30 to 21.00 which offers routine pre-bookable appointments with the practice nurse.

Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre bookable consultations up to two weeks in advance, same day 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 meetings and training. When the practice is closed patients access East Cheshire NHS Trust for primary medical services.

The practice is part of NHS Vale Royal Clinical Commissioning Group. It is responsible for providing primary care services to approximately 4,500 patients. The

practice is situated in an economically mixed area with some areas of deprivation. Seventy six per cent of patients have a long standing health condition which is above the national averaged when compared to other practices. Forty eight per cent of patients have health related problems in daily life and 21% of patients have caring responsibilities which is about average when compared to other practices nationally. The practice has a General Medical Services (PMS) contract.

The practice was in the process of registering for the regulated activities of maternity and midwifery and family planning.

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

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

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- 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 25th June 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, looked at survey results and reviewed comment cards left for us on the day of our inspection. We spoke with the practice manager, two GPs who were also the registered managers, practice nurse and reception and administrative staff on duty.

Are services safe?

Our findings

Safe Track Record

There was a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. We looked at a sample of records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff.

The practice held meetings at which significant events were discussed in order to cascade any learning points. We discussed significant events with clinical and non-clinical staff, they told us and we saw records which showed how they had recorded the event, the investigations undertaken, learning outcomes and action plans. Staff we spoke with told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally.

Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The contact details for both child and adult safeguarding teams were readily available for staff to refer to.

Records and staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role. Staff we spoke with demonstrated knowledge and understanding of safeguarding and its application.

One of the GPs was the lead for safeguarding. They attended meetings with and received regular updates from the safeguarding lead from the commissioning organisation who had recently provided a training session to all clinical staff and the practice manager. This

established link meant that advice and guidance could be easily sought when needed. Any concerns about the welfare of children were referred to the health visiting service for the area. The safeguarding lead told us they provided a report for child safeguarding meetings facilitated by social services as needed. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed.

Medicines Management

The GPs described the system in place for undertaking medicine reviews. GPs worked with the medicines management team from the Clinical Commissioning Group (CCG) to review prescribing trends and medicine audits. GPs reviewed their prescribing practices as and when medicine alerts were received and in accordance with good practice guidelines. One of the GPs had produced a protocol for the management of drugs liable to abuse which was now being used by the CCG medicines management team with other practices.

We looked at how the practice stored and monitored emergency medicines and vaccines. Vaccines were securely stored and were in date and organised with stock rotation evident. We saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of the vaccines. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We spoke to staff who managed the vaccines and they had a clear understanding of the actions they needed to take to keep vaccines safe. Emergency medicines were in date and held securely.

Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients or their representatives who attended the practice to collect them. Prescription pads were held securely. An inventory of prescription pad numbers was maintained to minimise the risk of misappropriation.

Cleanliness & Infection Control

Staff had access to an infection control policy with supporting processes and guidance. There was a lead member of staff for infection control who had completed training relevant to this role and who attended regular infection control meetings with the Clinical Commissioning Group. All staff had received training in infection control.

Are services safe?

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean. The layout and furnishings generally supported good infection control practices. We noted that the GP consultation rooms and one of the treatment rooms (used for phlebotomy) were carpeted and the couch in the treatment room had tape at the ends following damage to the cover. This may make these areas difficult to keep clean.

Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed hand washing facilities to promote hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

The Clinical Commissioning Group had carried out an infection control audit within the last 12 months. This indicated that overall the practice was meeting effective infection control standards. An action plan had been put in place to address shortfalls identified. The lead member of staff for infection control had also carried out their own audit in January 2015 and any issues identified had been addressed. A cleaning schedule was in place and regular checks were undertaken by the practice manager to ensure cleaning was carried out to a satisfactory standard. We were told that a risk assessment of the water safety systems had been undertaken to determine the risks presented by Legionella.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We were shown a certificate to demonstrate that equipment such as the weighing scales, vaccine fridge, thermometers and blood pressure machines had been tested and calibrated. All portable electrical equipment was routinely tested.

Staffing & Recruitment

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. In the event of unplanned absences staff covered from within the service. Duty rotas took into account planned absence such as holidays. Locum GPs provided cover for holidays and the same locums were used where possible to promote continuity for

patients. The registered manager and the practice manager told us that patient demand was monitored through the appointment system and staff and patient feedback to ensure that sufficient staffing levels were in place.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the recruitment records of a clinical and a non-clinical member of staff who were the last two staff to be employed. We found that improvements were needed to these records. Neither contained evidence of physical and mental fitness. One contained no references. The clinical member of staff had had their professional registration status checked prior to employment. A current check had been made against the General Medical Council website to ensure fitness to practice for both partner GPs and the locum GP. The practice manager told us they had also recently checked the NHS Performers List (a record held by NHS England of all GPs suitable to practice) but only had a record of this check for the locum GP.

Evidence of a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check was not available for the GPs (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). The practice manager told us that this information was not available as GPs need a CRB or DBS check to be included on the NHS Performers List. Confirmation from NHS England that this check had been undertaken was not available at the practice. The practice manager told us that some CRB checks of GPs would have been undertaken several years ago. A risk assessment to indicate when follow up DBS checks were to be undertaken was not in place. Administrative and reception staff who may act as a chaperone had received a DBS check. A risk assessment to indicate why a DBS check had not been carried out was not in place for the remaining administrative and reception staff.

Monitoring Safety & Responding to Risk

The practice had other systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, dealing with emergencies and monitoring the safety of equipment. Health and safety information was displayed for staff to see around the premises. The practice manager was the lead for health and safety and these issues were discussed at staff meetings. A health and safety

Are services safe?

audit of the building had been undertaken by an independent company in May 2015. An action plan was in place to address the shortfalls identified which were around improving record keeping.

All staff had been issued with a health and safety handbook. Records showed staff had received fire safety training and that the fire safety equipment was routinely tested. The practice was open one evening a week and at this time there were only two staff on the premises. Systems were in place to promote the safety of staff, such as an intercom and video surveillance. We noted that a risk assessment had not been recorded which would enable a review of the safety measures in place to ensure they continued to be effective.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available and staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had oxygen for use in the event of an emergency. This was appropriately stored and monitored to ensure suitability for use. We noted two

oxygen masks and tubing that had gone past their expiry date of February 2015 were being stored alongside ones that were in date. The out of date masks and tubing were removed during our visit. The practice had risk assessed the need for an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and concluded that this was not necessary. We noted that a record had not been made of this.

Staff told us they had up to date training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Training records confirmed that this training was up to date.

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of telephone system, loss of computer and electrical equipment, loss of utilities and staff incapacity. Key contact numbers were included for staff to refer to.

Panic buttons were available for staff on their computers and in the reception area for staff to call for assistance. The majority of staff had received training in managing abusive or aggressive patients.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were systems in place to ensure the clinical staff were familiar with new clinical protocols, the needs of patients with complex health needs were appropriately reviewed and to keep up to date with best practice guidelines and relevant legislation. GPs and the practice nurse attended training and educational events provided by the Clinical Commissioning Group (CCG) and they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers.

The practice nurse managed specialist clinical areas such as such as diabetes, asthma and cervical cytology. They kept their training up to date in these areas. This meant that they were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice provided several enhanced services which involved them working closely with the CCG to ensure patient needs were effectively assessed. For example, the practice took part in the avoiding unplanned admissions to hospital scheme. The clinicians discussed patient's needs at in-house and where appropriate at multi-disciplinary neighbourhood meetings and ensured care plans were in place and regularly reviewed.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients with learning disabilities, those who were on the palliative care register and patients using medicines liable to abuse.

Management, monitoring and improving outcomes for people

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) which were used to arrange annual health reviews.

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice used the information it collected for the Quality Outcomes Framework (QOF) to monitor the quality of services provided. The report from 2013-2014 showed the practice

was generally performing as expected when compared to other practices nationally. The QOF results indicated that the percentage of patients on the diabetes register whose cholesterol had been measured in the last 12 months was lower than expected when compared to the national average. The practice had a plan in place to address this shortfall.

A number of quality improvement audits were carried out. Examples of audits included endoscopy referrals, blood glucose testing, prescribing of medicines, minor surgery and telephone access. We looked at a sample of audits and found that the results either confirmed no changes were needed to practice or where necessary changes had been made to practice to improve patient care.

Effective staffing

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 two reception/administrative members of staff. They 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.

We spoke to two GPs who told us they had annual appraisals and we saw records to demonstrate that they undertook training/learning to inform their practice. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. We spoke to the practice nurse who told us they had annual appraisals and we saw records to demonstrate that they undertook training/learning to inform their practice. The practice nurse attended regular meetings with other nurses from the area and they said they received support from the GPs as needed and from the former practice nurse who was now employed in a different role at the practice. The practice nurse received an annual appraisal from the practice manager who did not have a clinical background and they did not have regular formal supervision from a clinical member of staff. Improvements should be made to the arrangements for ensuring clinical oversight of and support for this member of staff.

Are services effective?

(for example, treatment is effective)

Training records showed that staff had completed training to keep their skills and knowledge up to date. A system was in place to identify training needs and take action to address any shortfalls.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. 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, to enable staff to attend external training events or complete in-house training. The GPs, practice nurse and practice manager met monthly and shared information about new protocols and best practice guidelines.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. The practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Staff told us how information received from other agencies, such as A&E or hospital outpatient departments were read and actioned by the GPs in a timely manner. GPs described how blood result information would be sent through to them and the system in place to respond to any concerns identified. There was a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients.

The practice liaised with health and social care professionals such as the community nursing teams, health visiting service and mental health services to promote patient care. Neighbourhood meetings were held with clinical staff from local practices where the needs of and care plans for patients with complex needs were discussed. Palliative care meetings were held on a regular basis. Clinical staff met with district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify where further support may be required. The practice manager and health visitor met on a monthly basis to discuss any concerns around children's safety and wellbeing. A GP was linked to a care home in the area. The GP visited the home on a weekly basis and could be contacted by telephone for advice and support. This promoted continuity of patient care, effective communication and assisted in identifying ill health more easily.

Information Sharing

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

We noted a backlog of summarising of records of patients transferring from another practice. We were told that this was due to a member of staff being on maternity leave and that the plan was to prioritise this work in the next two months. In the interim, records had been arranged alphabetically for ease of access, the practice nurse was summarising questionnaires completed by new patients on to the computers and if provided GP to GP summaries had been scanned on to the computer. Following our visit the practice manager told us that further staff were being trained in summarising and would work additional hours to cover the backlog.

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hour's provider to enable patient data to be shared in a secure and timely manner and systems in place for making referrals to other health services.

The practice was implementing the electronic Summary Care Record and information was available for patients to refer to (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. 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, however, it had been identified that further training was needed in this area to update their skills and knowledge and this had been addressed. A Mental Capacity Act Policy was available for staff to refer to. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children

Are services effective?

(for example, treatment is effective)

aged under 16 who have the legal capacity to consent to medical examination and treatment). We were told that patient consent was gained for any surgical procedures and we saw the systems in place to record this.

Health Promotion & 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 and posters in the waiting area about the services available. This included smoking cessation, cancer screening, health checks and travel advice.

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. Quality and Outcomes Framework (QOF) information

showed the practice was generally meeting its targets regarding health promotion and ill health prevention initiatives. For example, the QOF results for March 2014 showed that the practice was performing as expected in relation to cervical screening of women aged 25 -65, number of patients experiencing poor mental health who have an agreed care plan and in relation to most diabetes checks. The QOF results indicated that the percentage of patients on the diabetes register whose cholesterol had been measured in the last 12 months was lower than expected when compared to the national average. The practice had a plan in place to address this shortfall.

New patients registering with the practice completed a health questionnaire. This asked the patient to provide information about their medical history, current health concerns and lifestyle choices. The practice nurse reviewed all patient health questionnaires and if any concerns were identified they arranged for the patient to see a GP.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We looked at 39 CQC comment cards that patients had completed prior to the inspection. Patients were overall 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. We spoke with six patients who were very positive about the services provided. They told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in published in January 2015 found that 82% of patients at the practice stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. Eighty four per cent said the GP was good at giving them enough time, 89% said the GP was good at listening to them and 79% said the GP was good at explaining tests and treatments. These responses were about average when compared to other practices locally and nationally.

Eighty five per cent of patients stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern and 84% said the nurse was good at listening to them. These responses were slightly higher than average when compared to other practices locally and nationally. Eighty per cent said the nurse was good at explaining tests and treatments and 81% said the nurse was good at giving them enough time. These responses were about average when compared to other practices locally and nationally.

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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and

treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations.

Information was provided to patients about the practice's zero tolerance for abusive 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 rated the practice well in these areas. For example, data from the National GP Patient Survey in published in January 2015 showed 80% of practice respondents said the GPs were good or very good at involving them in decisions about their care and 71% felt the nurses were good or very good at involving them in decisions about their care. These responses were slightly above average when compared to other practices locally and nationally.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated that overall they felt well supported, listened to and they had confidence in the clinical staff.

Patient/carer support to cope emotionally with care and treatment

Information was on display in the waiting area and on the practice website about the support available to patients to help them to cope emotionally with care and treatment. Information available included information about advocacy services, bereavement services and services for carers. A member of the Carers Trust spent one morning a month providing advice and support to patients and sign posting them to other services available. Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. There were counselling services and mental health support services which the GPs and nursing staff were able to refer patients on to.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with Vale Royal Clinical Commissioning Group (CCG) and neighbouring practices to address local needs and service improvements that needed to be prioritised. For example, the GPs had supported a paediatric clinic for children under 5 that was established at a neighbouring practice to alleviate winter pressure on a local hospital. To alleviate pressure on a local hospital and the out of hour's service over Easter 2015 the practice had also created extra appointments at the practice over a 3 day period.

The practice was part of the Care Home Scheme whereby a GP was linked to a care home in the area. The GP visited the home on a weekly basis and could be contacted by telephone for advice and support. Each patient had a care plan and an annual review of these patients was undertaken. This service promoted continuity of patient care, effective communication and assisted in identifying ill health more easily. We were told that this approach had led to a reduction in avoidable admissions to hospital. The practice attended neighbourhood meetings with clinical staff from local practices where the needs of patients with complex needs were reviewed and care plans altered if necessary.

The patients we spoke with told us about how the GPs had been responsive to their health needs. One told us that a GP had telephoned at the weekend to give advice following an accidental injury. Staff told us how the GPs visited palliative care patients in the evening and weekends to ensure continuity of care.

The practice worked to the National Gold Standard Framework in end of life care (The National Gold Standards Framework (GSF) Centre in End of Life Care provides training to enable generalist frontline staff to provide a gold standard of care for people nearing the end of life).

A record was kept of patients needing palliative care. Palliative care meetings were held on a regular basis. Clinical staff met with district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify where further support may be required.

The practice offered patients a chaperone prior to any examination or procedure. (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). Staff had received training around carrying out this role.

The practice had a Patient Participation Group (PPG). The purpose of the PPG 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 that sources of patient feedback such as complaints, surveys and emails to the practice had been reviewed with the PPG and an action plan had been put in place to address the issues identified. For example, the current action plan was to advertise the website, improve information available for carers and raise awareness of on line services. We met with a representative of the PPG who told us that improvements had been made to the practice as a result of their involvement, they said they felt they were listened to and that their opinions mattered.

Tackling inequity and promoting equality

The practice provided level access to all areas utilised by patients. An audit of access for patients had been recently undertaken by Life or Deaf Matters which identified what the practice was doing well and where any improvements needed to be made. An audio loop to assist patients with reduced ranges of hearing had been recently acquired. The practice staff knew how to obtain a British Sign Language interpreter if required.

Staff were knowledgeable about interpreter services for patients where English was not their first language. Information about interpreting services was available in the waiting area and information on the practice's website could be translated into different languages.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient had a learning disability then a double appointment was offered to the patient to ensure there was sufficient time for the consultation.

Access to the service

The practice was open Monday to Friday from 08.00 to 18.00. An evening surgery was provided on Tuesdays 18.30 to 21.00 which offered routine pre-bookable appointments with the practice nurse. Patients could book appointments in person, on-line or via the telephone. The practice

Are services responsive to people's needs?

(for example, to feedback?)

provided telephone consultations (including early morning 7.30- 9.00 for urgent issues), pre bookable consultations up to two weeks in advance, same day 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 meetings and training. When the practice was closed patients accessed East Cheshire NHS Trust for primary medical services.

The practice monitored patient access through patient and staff feedback. For example, a telephone access survey had been completed by patients to identify if this access continued to be satisfactory. The practice had identified that there were busy times when telephone access could be difficult and they had introduced changes to how the practice operated to address this. For example, through the promotion of on-line booking of appointment and prescription management.

The National GP Patient Survey published in January found that 83% of patients were very satisfied or fairly satisfied with opening hours. Eighty per cent said they didn't have to wait too long to be seen and 77% said the GP opening times were convenient. These responses were higher than average when compared to other practices locally and nationally. Seventy per cent rated their ability to get through on the telephone as easy or very easy and 74% described their experience of making an appointment as good. Eighty six per cent said they would recommend this practice to someone knew to the area. These responses were about average when compared to other practices nationally and higher than average when compared to other practices locally.

We looked at 39 CQC comment cards that patients had completed prior to the inspection. The comments indicated that patients were generally satisfied with access to the service. We spoke with six patients. They all said they were able to get an appointment when one was needed and that reception staff were friendly and helpful. They said that phone access to the practice was satisfactory, two said it could be hard getting through on the phone first thing in the morning. They all said they were satisfied with arrangements for repeat prescriptions and that if a referral to another service was needed this had been done in a timely manner.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. We discussed how complaints were managed with the GPs and practice manager. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. The complaint policy and procedure was displayed in the reception area. Reference was made to how to make a complaint and the complaint policy on the practice's website and in the patient information leaflet. The policy included contact details for the Health Service Ombudsman and NHS England, should patients wish to take their concerns outside of the practice. It also included details of patient advocacy and support services such as PALS (Patient Advice and Liaison Service).

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 aims and objectives were:-

“To provide the best possible quality service for patients within a confidential and safe environment by working together. To show patients courtesy and respect at all times. To involve allied healthcare professionals in the care of patients where it is in their best interests. To encourage patients to get involved in the practice through an annual survey, patient group and encouragement to comment on the care they receive. To ensure that all members of the team have the right skills and training to carry out their duties competently. To involve patients in decisions regarding their treatment.”

The aims and objectives were available in the statement of purpose for the practice which patients could request to see. Staff we spoke with were able to articulate the vision and values of the practice. Comments from patients we spoke with indicated they were happy with the standard of care received, they were consulted and treated with respect.

Governance Arrangements

Meetings took place and there were systems in place to share information, look at what was working well and where any improvements needed to be made. For example, the GPs, practice nurse, practice manager and administrator met regularly to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. Practice meetings involving the whole staff team also took place. The business manager and the registered managers frequently discussed the operation of the practice and any actions needed to improve the operation of the service.

The practice had a number of policies and procedures in place to govern activity and staff knew how to access them. We looked at a sample of policies and procedures and they had been recently reviewed and contained the required information.

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.

Quality improvement audits were carried out. Examples of audits included endoscopy referrals, blood glucose testing, prescribing of medicines, minor surgery and telephone access. We looked at a sample of audits and found that the results either confirmed no changes were needed to practice or where necessary changes had been made to practice to improve patient care.

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. Staff told us that the outcome of significant incidents and complaints and how they were to be learned from were discussed.

Leadership, openness and transparency

We spoke with 8 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. They 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 registered managers. Staff told us they felt the practice was well managed and they could raise concerns and felt they were listened to.

Human resource policies and procedures, for example, the induction, sickness and absence and disciplinary procedures were available for staff to refer to. These procedures were in a staff handbook. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow.

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

Patient feedback was obtained through carrying out surveys, reviewing the results of national surveys, comments and suggestions forms and through the complaint procedure.

The practice had a Patient Participation Group (PPG). The purpose of the PPG 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 that sources of patient feedback such as complaints, surveys and emails to the practice had been reviewed with the PPG and an action plan had been put in place to address the issues identified. For example, the current action plan was to advertise the website, improve information available for

Are services well-led?

Good 

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

carers and raise awareness of on line services. We met with a representative of the PPG who told us that improvements had been made to the practice as a result of their involvement, they said they felt they were listened to and that their opinions mattered.

A leaflet was on reception and handed out to patients encouraging them to access and participate in the NHS friends and family test. 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. Results from January to April 2015 showed that patients who had responded were either “extremely likely” or “likely” to recommend the practice.

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.

Management lead through learning & improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement

opportunities. Staff were offered annual appraisals to review performance and identify development needs for the coming year. Staff told us the practice was supportive of their learning and development needs and that they felt supported in their roles. Although the practice nurse had access to on going daily clinical support as required, their annual appraisal was carried out by the practice manager who did not have a clinical background and they did not have regular formal supervision from a clinical member of staff. Improvements should be made to the arrangements for ensuring clinical oversight and support for this member of staff.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Patients were not protected against the risks associated with unsuitable staff because the provider did not ensure that information specified in Schedule 3 was available for all staff employed.