

# Danebridge Medical Practice

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Danebridge Medical Practice. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services to meet the needs of all population groups of patients. We found that some improvements should be made to record keeping in relation to the safety of the service.

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

- There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for 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. The staffing numbers and skill mix were reviewed to ensure that

patients were safe and their care and treatment needs were met. We found improvements should be made to the records for staff recruitment and the management of medical equipment.

- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.
- Feedback from patients showed they were overall 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

- There was a clear leadership structure in place. 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 should:

- Make a record of the physical and mental fitness of staff during the recruitment process.
- Review the system at Kingsmead Medical Centre for ensuring defibrillator pads and oxygen masks for children are immediately accessible to staff in an emergency.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for 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. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. We found that the recruitment practices should be improved by recording an assessment of the physical and mental fitness of staff. The system for ensuring all emergency equipment is immediately accessible to staff in an emergency should be reviewed.

Good



### 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. 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 spoken with were 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 service to identify patient needs and service improvements that

Good



# Summary of findings

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. There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to. The practice had systems to seek and act upon feedback from 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. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care. GPs were linked to the residential and nursing homes in the area. The GPs visited each home on a weekly basis and could be contacted by telephone for advice and support. Each care home patient had a care plan and a thorough 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 and an annual health check that incorporated health education to maintain a healthy lifestyle. The practice carried out a review of patients over 75 who had been discharged from hospital to ensure all necessary GP services were being provided and to signpost the patient to health and social care services if needed. The practice worked with other agencies and health providers to provide support and access specialist help when needed. Older people also benefitted from the triage service that was offered every day. This gave rapid access to a clinician for advice or face to face consultation or early visiting.

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. Clinical staff kept up to date in specialist areas which helped them ensure best practice guidance was always being considered. The practice had achieved and implemented the Gold Standards Framework for end of life care. Gold Standards Framework meetings were held alongside multi-disciplinary meetings every month where the needs of patients with terminal illnesses and complex health needs were discussed. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

Good



# Summary of findings

## 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. An immediate appointment or triage was offered to all children under one to ensure rapid access to a clinician. A complete family planning service was available. Routine contraceptive advice and prescribing was provided and in response to patient needs a weekly vasectomy clinic and a gynaecological clinic were provided where implants and coils were fitted. These clinics were run at set times to assist patient access and were managed by a dedicated practice nurse. 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. Liaison took place with the health visiting service to discuss any children who were at risk of abuse. Regular meetings with the health visiting service had been recently set up in order to provide a more formal basis for sharing concerns and reviewing if any further actions were necessary.

Good



## 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). Danebridge Medical Practice was open Tuesday to Friday from 08.00 to 18.30 and from 08:00 to 21:00 on Mondays. As well as the extended hours evening service the practice was planning to offer early morning appointments between 07:00 and 08:00 two days a week as a result of securing funding from the Prime Ministers Challenge Fund. The practice provided telephone consultations, pre bookable consultations up to two weeks in advance, same day appointments and a triage service to offer advice and signpost patients. On line bookable appointments and on line prescription requests were available. The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation, sexual health screening and contraceptive services. 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

Good



# Summary of findings

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.

## **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. Patients experiencing poor mental health were encouraged to have two GPs to promote continuity of care. A counselling service was provided from the same premises which clinical staff could refer patients to. The practice referred patients to appropriate services such as psychiatry as needed. Telephone consultations and the triage service provided support to patients suffering from extreme anxiety and phobias. The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

Good





# Summary of findings

## What people who use the service say

We looked at 41 CQC comment cards that patients had completed prior to the inspection and spoke with seven patients. The majority of patients were 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 told us they had enough time to discuss things fully with the GP, treatments were explained, they felt listened to and involved in decisions about their care.

The National GP Patient Survey published in January 2015 found that 79% 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 percent said the GP was good at listening to them. Seventy one percent 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 70% said the nurse was good at listening to them. These responses were about average when compared to other practices nationally. Sixty nine percent of practice respondents said the GPs were good at involving them in decisions about their care and 61% felt the nurses were good at involving them in decisions about their care. Seventy eight percent of respondents said the GPs were good at explaining tests and treatments and 68% said the nurses were good at explaining tests and treatments. These responses were about average when compared to other practices nationally. Eighty percent of patients who responded to this survey described the overall experience of their GP surgery as good. This was higher than the national average.

The CQC comment cards that patients had completed prior to the inspection indicated that patients were generally happy with the standard of care provided and a number mentioned being able to get an appointment

when they needed one. Four patients commented that appointments could be difficult to get. We spoke with seven patients who said they had seen an improvement to the appointments system and that they were able to get an appointment when one was needed. They described the reception staff as friendly and helpful.

The National GP Patient Survey found that 87% of patients said they were able to see or speak to someone the last time they tried and 97% said the appointment they got was convenient. These responses were about average when compared to other practices nationally. Sixty percent described their experience of making an appointment as good, which was below the national average but average when compared to other practices in the area. Forty one percent of respondents said they found it easy to get through to the practice by phone. This was significantly below average when compared to other practices nationally.

The practice manager and reception manager told us that the reception had been reorganised in April 2015 to improve telephone access for patients. Comments made by patients via the NHS friends and family test (FFT) (the FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment) showed that from December 2014 – April 2015 patients had raised the issue of telephone access but since the reorganisation of the reception these comments had significantly reduced. The practice manager told us that the phone system was provided through the former Primary Care Trust and that the practice was working with the information technology department of the Clinical Commissioning Group to enable the system to function as efficiently as possible. The practice had reminded patients through notices in the waiting area and the practice website to phone outside of busy times if not phoning for an appointment.

## Areas for improvement

### Action the service SHOULD take to improve

The provider should:

- Make a record of the physical and mental fitness of staff during the recruitment process.

# Summary of findings

- Review the system at Kingsmead Medical Centre for ensuring defibrillator pads and oxygen masks for children are immediately accessible to staff in an emergency.

# Danebridge Medical Practice

## 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 second inspector, GP and a practice manager specialist advisors.

## Background to Danebridge Medical Practice

Danebridge Medical Practice is based in Northwich, Cheshire. There are two branch surgeries, Kingsmead Medical Centre, based in Northwich and Sandiway Surgery, based in Sandiway, approximately four miles away from the Danebridge Medical Practice. During this inspection we visited Danebridge Medical Practice and Kingsmead Medical Centre.

The practice treats patients of all ages and provides a range of medical services. At the time of our visit the staff team included eight GP partners, seven salaried GPs, three GP Registrars (a registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice) one Foundation Year 2 Doctor (the Foundation Programme is a two year training programme for doctors who have just graduated from medical school) nine practice nurses, two health care assistants, a practice manager, reception manager, IT administrator and reception and administrative staff.

Danebridge Medical Practice is open Tuesday to Friday from 08.00 to 18.30 and from 08:00 to 21:00 on Mondays. The branch practices, Kingsmead and Sandiway are open Monday to Friday 08:00 – 13:00, with Kingsmead opening in the afternoon from 14:00 to 18.30. 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 triage nurse or emergency GP deals with requests for home visits and telephone advice to ensure these requests best meet the patient's needs. When the practice is closed patients access East Cheshire 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 23,800 patients. The practice is situated in an economically less deprived area when compared to other practices nationally. Fifty one percent of patients have a long standing health condition, 51% of patients have health related problems in daily life and 16% of patients have caring responsibilities. The majority of the patient population are between the ages of 35 and 69. The practice has a General Medical Services (GMS) contract.

Health and community services such as health visiting, district nursing, midwifery, counselling, and phlebotomy operate from the premises.

## 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.

# Detailed findings

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:

- 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 9th 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, registered manager, GPs, nurse manager, reception manager, administrative staff and reception staff on duty.

# Are services safe?

## Our findings

### Safe Track Record

NHS Vale Royal Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. 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.

Alerts and safety notifications from national safety bodies were dealt with by the clinical staff and the practice manager. Staff confirmed that they were informed about and involved in any required changes to practice or any actions that needed to be implemented.

### 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. We viewed analysis documentation which included details of the events, details of the investigations, learning outcomes and action plans. Records showed that where necessary appropriate action had been taken to ensure patient safety was promoted.

There was evidence that appropriate learning had taken place following a significant event 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. There was a system in place to ensure all relevant staff received this information if they did not attend these meetings. Staff we spoke with told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally.

A central log/summary of significant events was maintained that would allow patterns and trends to be easily identified and enable a record to be made of actions undertaken and reviewed.

### Reliable safety systems and processes including safeguarding

Staff had access to safeguarding policies and procedures for both children and adults who may be vulnerable due to their circumstances. These provided staff with information about identifying, reporting and dealing with suspected

abuse. The policies were available to staff and we saw that all staff had signed to say they had read and understood them. Staff had access to contact details for both child and adult safeguarding teams.

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 a good knowledge and understanding of safeguarding and its application. We looked at a sample of training records that confirmed staff had attended this training. Training to update all staff had been provided by the safeguarding lead GPs in February 2015.

Two GPs took the lead for safeguarding children and vulnerable adults. One GP was the named GP lead for Child Safeguarding for Vale Royal Clinical Commissioning Group and gave advice, support and training to other GPs in the local area. The practice had clear systems in place to monitor and respond to requests for attendance/reports at safeguarding meetings. 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.

Any concerns about the welfare of children were referred to the health visiting service for the area. Regular meetings with the health visiting service had been recently set up in order to provide a more formal basis for sharing concerns and reviewing if any further actions were necessary.

### Medicines Management

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. The GPs told us they re-authorised medicines in accordance with the needs of patients and a system was in place to highlight patients requiring medicine reviews. Patient medicine reviews were undertaken during consultations and chronic condition reviews.

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

## Are services safe?

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.

Prescription pads were held securely. An inventory of prescription pad numbers was maintained to minimise the risk of misappropriation. The practice reported any concerns relating to the management of medicines at the practice or at other services, for example, hospitals and care homes to the CCG in order to promote patient safety.

### 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. The staff we spoke with told us they had received training in infection control appropriate to their role.

We looked around the premises at Danebridge Medical Practice and Kingsmead Medical Centre and found them to be generally clean. Some areas of Danebridge Medical Practice, such as carpets and paintwork were showing signs of wear and tear as although they had been cleaned they appeared stained in places. In general the treatment rooms had surfaces that could be easily cleaned. Some GP consultation rooms were carpeted, some chairs in the waiting areas were covered in fabric and the examination couch in one of the GPs rooms was wooden, these materials were porous and can be difficult to keep clean. One of the cleaning cupboards needed attention as this did not promote good infection control practices. The flooring and surfaces were not easily wipeable and soap and paper towels were not easily accessible.

The Clinical Commissioning Group carried out infection control audits with the last one undertaken at Danebridge Medical Practice in February 2015. This indicated that overall the practice was meeting effective infection control standards. However, they identified improvements were needed to raise standards. These included the issues identified above. The practice manager told us there was a plan in place to address the shortfalls identified, for example, the carpet in three GP consultation rooms was being replaced and these rooms were being redecorated in the next two months. All carpets had been cleaned since

the audit and the cleaning cupboard had been re-organised. We noted that a formally recorded action plan with timescales for all improvements was not available.

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 good standards of 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. Checks were carried out to ensure items such as instruments, gloves and hand gels were available and in date. However, we identified some out of date dressings and syringes during our visit. These were disposed of immediately. The registered manager told us they would review their systems for ensuring equipment is in date.

A cleaning schedule was in place and regular checks were undertaken by a designated member of staff at the practice to ensure cleaning was carried out to a satisfactory standard. We were told that water safety systems were checked to guard against the risk of 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.

## Are services safe?

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 two clinical and a non-clinical members of staff who were the last staff to be employed. We found that the recruitment procedure had in general been followed and the required checks had been undertaken to show the applicants were suitable for their posts. We noted that a record of the physical and mental fitness of staff had not been made. Following our visit the registered manager told us that this had been put in place.

All clinical staff had received a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check and we looked at a sample of records to confirm this (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). A risk assessment was available to indicate why non-clinical staff did not need a DBS check. The professional registration of clinical staff was checked prior to appointment. We saw that a recent check of the Performers List had been undertaken for all GPs at the practice and we were told that a recent check of the registration of all staff with the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) had been carried out, however, we noted that this had not been recorded. The registered manager told us that a system for recording regular checks of continuing NMC and GMC registration would be put in place.

### Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included managing and learning from significant events, medicines management and safeguarding vulnerable adults and children from abuse. A health and safety policy and procedure was available. Health and safety information was displayed for staff to see around the premises. One of the GP partners was the lead for health and safety and these issues were discussed at staff meetings. We looked at a sample of records of checks made to ensure the safety of the premises at Danebridge Medical Practice and Kingsmead Medical Centre. We noted that a fire risk assessment was not in place for Danebridge

Medical Practice and there was no evidence that the emergency lighting was checked periodically to ensure it was functioning adequately. The practice manager had identified these shortfalls prior to our visit and had booked an external fire safety company to undertake this work on 17th June 2015. Following our visit we were advised that this had been postponed by the company until 15th July 2015.

### 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. The practice also had access to automated external defibrillators (used to attempt to restart a person's heart in an emergency). We found that an oxygen mask for a child and a defibrillator pad for a child could not be located speedily at Kingsmead Medical Centre when we asked to see this equipment. The location of these items was identified shortly afterwards. The system for ensuring all emergency equipment is immediately accessible should be reviewed to ensure all staff can access this equipment in an emergency.

Staff told us they had up to date training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). Samples of training certificates confirmed that this training was up to date. We noted that drills to test out the accessibility of emergency equipment and staff response times were not undertaken.

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 treatment rooms and in the reception area for staff to call for assistance.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice. Clinical staff attended regular training and educational events provided by the Clinical Commissioning Group and they had access to recognised good practice clinical guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines on their computers. The GPs met weekly to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines, clinical research and relevant legislation. Nurses met in-house and with nurses from other practices which assisted them in keeping up to date with best practice guidelines and new clinical protocols. Clinicians also attended training events and meetings relating to a specific clinical area, for example, all clinicians involved in diabetes care or family planning met to share information to update practice and ensure safe patient care.

The GPs specialised in clinical areas such as diabetes, dermatology, family planning and sexual health. They also specialised and took the lead with different patient groups such as women's health, children's health and the health of patients with learning disabilities. The practice nurses managed specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD), childhood immunisations and cervical screening. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

One of the GPs was a member of the skin multi-disciplinary team at the hospital that would provide histology on any minor surgical procedures. This link meant that there was good communication around any patients requiring follow up treatment and that the practice was kept up to date in its service provision.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital promptly to ensure an appointment was provided within two weeks.

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 and those who were on the palliative care register.

### 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 meeting national targets for example, in relation to checks for patients with diabetes, blood pressure readings for hypertensive patients, cervical screening and maintaining a register for adult patients with a learning disability and patients in need of palliative care.

We saw that audits of clinical practice were undertaken. Examples of audits included an audit of the prescribing of Metformin for all type 2 diabetics at the practice. This was first commenced in 2013 and over the past 2 years had shown significant improvements in the numbers of patients prescribed Metformin as a result of the intervention. An audit of patients with dementia in order to ensure diagnosis was being followed up and that patients and carers were in touch with or signposted to the appropriate support organisations. An audit of the management of patients with atrial fibrillation, to ensure they were receiving the most appropriate medication. The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of Quality and Outcomes Framework (QOF) performance. All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement.

The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, safeguarding and promoting the health care needs of patients with a learning



# Are services effective?

(for example, treatment is effective)

disability. The practice had achieved and implemented the Gold Standards Framework for end of life care. They kept a record of patients needing palliative care. Gold Standards Framework meetings were held alongside multi-disciplinary meetings every month where the needs of patients with terminal illnesses and complex health needs were discussed. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

## 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 non-clinical staff 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. We spoke to GPs and the practice nurse manager who told us they had annual appraisals and completed training to keep their skills and knowledge up to date, 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. A mentorship programme was in place for newly qualified and salaried GPs.

The staff we spoke with told us they felt well supported in their roles. 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 met weekly to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. These meetings included presentations from visiting consultants. The nursing staff met regularly and they attended training events with other nurses in the area. The reception and administrative staff met to discuss their roles and responsibilities and share information. The practice manager attended monthly meetings for practice managers within the Vale Royal CCG and specifically for

practice managers within the Northwich area to keep up to date with new developments. The practice manager also attended meetings with the CCG when relevant topics were going to be discussed.

## 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.' 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. Multi-disciplinary team and 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. GPs were invited to attend child and vulnerable adult safeguarding conferences, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. A GP was linked to the residential and nursing homes in the area. The GPs visited each 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.

The practice had systems in place to communicate with other providers. For example, there was a system for

# Are services effective?

(for example, treatment is effective)

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 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. The clinical staff had received a training update in the Mental Capacity Act and Deprivation of Liberty Safeguards in February 2015. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). A procedure was in place for gaining verbal and written consent from patients, for example, when providing joint injections and minor surgical procedures.

## Health Promotion & Prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion

information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available. This included smoking cessation, various cancers 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 meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions.

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

The practice 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 annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We looked at 41 CQC comment cards that patients had completed prior to the inspection and spoke with seven patients. The majority of 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 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 published in January 2015 found that 79% 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 percent said the GP was good at listening to them. Seventy one percent 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 70% said the nurse was good at listening to them. These responses were about average when compared to other practices nationally. Eighty percent of patients who responded to this survey described the overall experience of their GP surgery as good. This was higher than the national average.

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 private. Curtains were generally provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that some nurses treatment rooms did not have curtains although the doors were lockable. We observed 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

Data from the National GP Patient Survey published in January 2015 showed 69% of practice respondents said the GPs were good at involving them in decisions about their care and 61% felt the nurses were good at involving them in decisions about their care. Seventy eight percent of respondents said the GPs were good at explaining tests and treatments and 68% said the nurses were good at explaining tests and treatments. These responses were about average when compared to other practices 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 they generally felt listened to, supported 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 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. Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. A bereavement protocol had been developed to ensure bereaved relatives had contact from the most appropriate GP soon after the bereavement. There were counselling services and mental health support services which the GPs and nursing staff were able to refer patients on to. A register of carers was maintained and once a month a representative from the Cheshire Carers Association came to the practice to raise awareness and offer help and signposting for carers.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice engaged with NHS Vale Royal Clinical Commissioning Group (CCG) to address local needs and service improvements that needed to be prioritised.

The practice had identified the need for closer working relationships with local residential and nursing homes in order to support the health needs of patients. GPs were linked to the residential and nursing homes in the area. The GPs visited each home on a weekly basis and could be contacted by telephone for advice and support. Each patient had a care plan and a thorough 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 and had been adopted by the CCG as a funded service for other practices to opt into. A monthly meeting was held with representatives from all the nursing and residential homes to discuss what was working well and where improvements could be made.

In response to patient need the practice had established a weekly vasectomy clinic and a gynaecological clinic where implants and contraceptive coils were provided. The practice had four GPs trained in fitting contraceptive coils and implants and one nurse trained in the fitting and removal of implants. These clinics were run at set times to assist patient's access and were managed by a dedicated practice nurse.

Referrals for investigations or treatment were mostly done through the "Choose and Book" system which gave patients the opportunity to decide where they would like to go for further treatment. Administrative staff monitored referrals to ensure all referral letters were completed in a timely manner.

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).

Gold Standards Framework meetings were held alongside multi-disciplinary meetings every month where the needs of patients with terminal illnesses and complex health

needs were discussed. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

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). The nursing staff and health care assistants acted as chaperones. The nursing staff had received training around carrying out this role and the health care assistants had received guidance. The practice had a plan in place to provide formal training to the health care assistants and to train some administrative staff to act as chaperones following the receipt of a satisfactory Disclosure and Barring Service check (DBS).

The practice had a Patient Reference Group (PRG). The purpose of the PRG 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. Surveys sent by the practice were agreed with the PRG and an action plan devised with them. The practice met with the PRG on a monthly basis. Records showed the action taken by the practice as a result of patient surveys and meetings with the PRG. For example, improving access to pre-bookable and on the day appointments and improving the patient's experience of booking appointments. We met with a representative of the PRG 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 disabled access in the reception and waiting areas, as well as in the consulting and treatment rooms. Disabled parking facilities were available. A baby changing facility was available and an audio induction loop was available for patients with reduced ranges of hearing.

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.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order

# Are services responsive to people's needs?

## (for example, to feedback?)

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.

Staff spoken with indicated they had received training around equality, diversity and human rights.

### Access to the service

The main practice, Danebridge Medical Practice was open Tuesday to Friday from 08.00 to 18.30 and from 08:00 to 21:00 on Mondays. The branch practices, Kingsmead and Sandiway were open Monday to Friday 08:00 – 13:00, with Kingsmead opening in the afternoon from 14:00 to 18.30.

Patients could book appointments in person, on-line or via the telephone. The practice provided telephone consultations, 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 triage nurse or emergency GP dealt with requests for home visits and telephone advice to ensure these requests would best meet the patient's needs. When the practice is closed patients access East Cheshire Trust for primary medical services.

The National GP Patient Survey published in January 2015 (based on data collected January-March 2014 and July-September 2014) found that 87% of patients were able to see or speak to someone the last time they tried and 97% said the appointment they got was convenient. These responses were about average when compared to other practices nationally. Sixty percent described their experience of making an appointment as good, which was below the national average but average when compared to other practices in the area. Forty one percent of respondents said they found it easy to get through to the practice by phone. This was significantly below average when compared to other practices nationally.

The practice manager and reception manager told us that the reception had been reorganised in April 2015 to improve telephone access for patients. Comments made by patients via the NHS friends and family test (FFT) (the FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment) showed that from December 2014 – April 2015 patients had raised the issue of telephone access but since the reorganisation of the reception these comments had significantly reduced. The practice manager told us that the phone system was

provided through the former Primary Care Trust and that the practice was working with the information technology department of the Clinical Commissioning Group to enable the system to function as efficiently as possible. The practice had reminded patients through notices in the waiting area and the practice website to phone outside of busy times if not phoning for an appointment.

We looked at 41 CQC comment cards that patients had completed prior to the inspection. The comments indicated that patients were generally happy with the standard of care provided and a number mentioned being able to get an appointment when they needed one. Four patients commented that appointments could be difficult to get and three of those patients said it could be difficult getting an appointment with the same GP. We spoke with seven patients. They all said they had seen an improvement to the appointments system and that they were able to get an appointment when one was needed. They described the reception staff as friendly and helpful.

The practice had a newsletter. We saw the current newsletter was available at the reception desk. The newsletter provided information about any changes to the practice and useful information about services offered at the practice and in the community. For example, the latest newsletter contained information about the electronic prescribing service and reminded patients to cancel any appointments they were not able to attend so that the appointment was not wasted.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available 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 NHS England, the Health Service Ombudsman and the Care Quality Commission, should patients wish to take their concerns outside of the practice. Details of advocacy services to support patients making a complaint were also included in the procedure.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. A complaints log was maintained to enable patterns and trends to be identified.

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

The GPs and practice manager reviewed complaints made on a regular basis to ensure common themes were identified and any actions to improve patient care were implemented.

# 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 the following mission statement:-

“To provide the best healthcare we can for our patient population by applying best practice at every level, clinical and non-clinical, to ensure the best outcomes for all.

We value patient involvement, we encourage on going staff development and we have an active doctors’ education programme to ensure we are continuing to strive towards current best practice.”

The mission statement was recorded in the statement of purpose for the practice which was available to patients on request. The registered manager told us that the mission statement was also going to be put on to the practice website and included in the patient information handbook. A patients’ charter was available detailing the service patients could expect from the practice.

### Governance Arrangements

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. Clinical staff met to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. The reception and administrative staff met to discuss their roles and responsibilities and share information. Partners and managers meetings took place to look at the overall operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format. We looked at a sample of policies and procedures and found that the policies and procedures required were available and up to date.

The practice used the Quality and Outcomes Framework (QOF) and other performance indicators 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 systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

### Leadership, openness and transparency

There was a leadership structure in place and clear lines of accountability. We spoke with clinical and non-clinical 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, reception manager or registered manager. Staff told us they felt the practice was well managed with clear leadership from clinical staff and the practice and reception manager. Staff told us 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 and a national website for patient feedback, comments and suggestions forms and through the complaint procedure.

The practice had a Patient Representative Group (PRG). The purpose of the PRG 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. Surveys sent by the practice were agreed with the PRG and an action plan devised with them. The last patient survey was carried out between November 2013 and January 2014 and the results were made available for patients to view on the practice website.

# Are services well-led?

Good 

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

The results indicated that patients wanted better access to pre-bookable appointments, a virtual PRG, improvements to the decoration of the premises and better access to the practice by telephone. Records showed that an action plan had been agreed with the PRG as to how to address these issues. We met with a representative of the PRG 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. This could also be completed on-line. 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 March to May 2015 showed that the majority of 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 well supported in their roles. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other.

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.