Culcheth Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Culcheth Medical Centre on 20 May 2015. Overall the practice is rated as **good.**

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups it serves.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered in line with best practice guidance. Staff had received training appropriate for their roles and any further training needs had been identified and planned.
- Patients spoke highly about the practice and its staff. They said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available on the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

Summary of findings

- The practice ensured patient experience played an important role in improving quality service delivery. The practices Patient Participation Group were an important part of this. The group undertook regular patient surveys and developed actions plans with the practice where negative comments were made. They held annual community events to raise the profile of the practice amongst the local community. They engaged local schools by inviting the young adults to their PPG meetings to gain their views on how services could be developed. Working with the practice the PPG had planned a local community event for this summer to specifically target those patients who are social isolated. The aim of this was to bring together older and more socially isolated patients to ensure they know the full range of services provided by the practice and to gain their views on how services could be improved.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should;

- Improve the current system for clinical audit to ensure full and completed audits are undertaken.
- Ensure doctors have emergency drugs available for use or have in place a risk assessment to support their decision not to have these available for use in a patient's home.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from The National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Systems were in place to manage, monitor and improve outcomes for patients. Effective staffing arrangements were in place. Some audits were carried out by the practice but an audit programme was not in place to ensure audit cycles were always completed.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice high in terms of how caring staff were. Patients we spoke with on the day of the inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was available and easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice demonstrated how it learned from complaints in co-operation with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. There was a clear leadership structure and staff felt supported by management. Regular practice meetings took place. The practice had a number of policies and procedures to govern activity and held regular practice meetings, though reception and administration staff did not routinely attend these. All staff were allocated protected learning time and training that enabled them to deliver their duties effectively and safely. There were systems in place to monitor and improve quality and identify risk, though audit activity required improvement. The practice proactively sought feedback from staff and patients, which it acted on. Risk assessments were in place. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly experienced by older people. All patients over 75 had a named, accountable GP. The practice was participating in the Warrington Health Plus Nursing Home project, which included two GPs spending one day per week focussing on the needs of nursing home patients. The aim of this was to prevent unplanned hospital admissions and to reduce daily GP visits to the homes. Community events were organised by the practice and their Patient Participation Group. Working with the practice the PPG had planned a local community event for this summer to specifically target those patients who are social isolated.

The practice had undertaken electronic searches of this population group, including identifying those patients who lived alone, who had caring responsibilities and who had been seen in the last 12 months. Older patients with chronic, complex medical conditions and social needs had their own community matron assigned to them, undertaking home visits as required. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, offering flu vaccination and home visits if needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice monitors unplanned admissions to hospital for patients with long term conditions. Any patients admitted to hospital were contacted within one week to assess if they require additional primary care support services. The practice had achieved full Quality results for the Outcomes Framework (QOF) relating to their management of Diabetes, Asthma, Coronary Obstructive Pulmonary Disease (COPD), Heart Disease, Heart Failure and Rheumatoid Arthritis in the last QOF year.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were just below the CCG average for most of the standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice undertakes a joint six week child assessment including the administration of childhood vaccines. Patient information sign posted young people to sexual health services in the area.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offers a range of appointment times for working people, from 8am on a Monday, and up to 7.30pm on a Tuesday and Wednesday. The practice was proactive in offering online and telephone services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances and annual health checks were carried out for this population group. Staff were knowledgeable about how to support patients with alcohol and drug addiction problems sign posting them to support services locally.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

The practice offered annual reviews to all patients who have a learning disability. Those patients who were in a nursing homes or were housebound were offered a home visit for full review.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Systems were in place to ensure people experiencing poor mental health had received an annual physical health check. This included identifying those patients on the practice register that may benefit from a dementia needs review. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice offered a full mental health support service for patients in partnership with neighbouring mental health trusts. Patients can self-refer for counselling for anxiety, stress and depression.

A number of patient information leaflets and posters were seen in the waiting area, sign posting patients to agencies that could provide support to the patient or their families.

Summary of findings

What people who use the service say

We received 15 Care Quality Commission (CQC) comment cards which patients had completed before our inspection. Eleven of the comments made were positive including how caring staff are, how supportive they were and how the environment is clean and tidy. Four cards gave negative comments and these related to poor staff attitude and the lack of availability of GP appointments. We spoke with six patients throughout the morning and in the afternoon. Those we spoke with told us of the caring, supportive and friendliness of the staff and their confidence in the GPs and nurses at the practice.

During our inspection we spoke with two members of the Patient Participant Group (PPG). They told us the practice worked closely with their group to develop the services for the practice patients. The practice had reported to them the results of their patient survey which had been carried out in December 2014. Patients shared their views on how helpful staff were, privacy and overheard conversations at the reception, appointment times and long waits when seeing the GP. We saw an action plan had been put into place to address these patient comments.

The NHS England GP Patient Survey, published on 8 January 2015, gives more up to date information on the service provided by the practice. Data for this survey was collected between January and March 2014, and July and September 2014. This survey showed that the practice performed well compared to practices of a similar size in the Warrington area and in England. For example, the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good was 91% compared with 85% nationally. The proportion of respondents to the GP patient survey who 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 was 96% compared with 85% nationally. Patients said the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care, the figure was 82% compared to 85% nationally. Patients' responses showed 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. The figure was 92% compared to the national 90% response rate.

Areas for improvement

Action the service SHOULD take to improve

- Improve the current system for clinical audit to ensure full and completed audits are undertaken.
- Ensure doctors have emergency drugs available for use or have in place a risk assessment to support their decision not to have these available for use in a patient's home.

Outstanding practice

We saw some areas of outstanding practice including:

- The practice ensured patient experience played an important role in improving quality service delivery. The practices Patient Participation Group were an important part of this. The group undertook regular patient surveys and developed actions plans with the practice where negative comments were made. They held annual community events to raise the profile of the practice amongst the local community. They engaged local schools by inviting the young adults to their PPG meetings to gain their views on how services could be developed. Working with the practice the PPG had planned a local community event for this summer to specifically target those patients who are social isolated. The aim of this was to bring together older and more socially isolated patients to ensure they know the full range of services provided by the practice and to gain their views on how services could be improved.

Culcheth Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspector was accompanied by a specialist GP and Practice Manager Advisor.

Background to Culcheth Medical Centre

Culcheth Medical Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 6969 patients living in the Warrington area. The practice has five GPs both male and female, a practice manager with supportive management team, two practice nurses, a phlebotomist, administration and reception staff. Culcheth Medical Centre holds a Personal Medical Services (GMS) contract with NHS England.

The practice opening hours are Monday to Friday from 08.00 to 6.00 most days. Early morning and late evening sessions are also available on set days, these are reserved and pre bookable. The practice treats patients of all ages and provides a range of primary medical services. Outside of these hours the practice will divert patients that phone the practice to the out of hour's service commissioned by Warrington CCG.

The practice is part of NHS Warrington Clinical Commissioning Group (CCG) and is situated in an area with lowerdeprivation. The practice population has a higher than national average patient group aged 65 years and over. There are lower deprivation scores for patients in this area compared to national figures.

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.

How we carried out this inspection

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

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

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

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

Detailed findings

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 20 May 2015.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face before and during the inspection. We looked at survey results and reviewed CQC comment cards completed by patients to share their views of the service. We spoke with the GPs, nurses, administrative staff and reception staff on duty. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We explored how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with carers and family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we looked at a reported incident relating to a number of medicines and prescription errors had occurred. We saw these matters had been investigated, appropriate action was taken at the time. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. We noted that improvements were needed to the records made to show the discussions that had taken place amongst clinicians when an incident had occurred. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system they used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example an incident had occurred whereby there was a delay in the referral of patients to hospital for treatment because the doctor did not have the time during the consultation to make this referral. Doctors now have uninterrupted time at the end of each mornings to make such a referral in a timely way. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

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

Reliable safety systems and processes including safeguarding

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health

visitors and the local authority. The practice had a system in place for identifying children and young people with a high number of A&E attendances and these were monitored closely by the practice.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks, (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

The practice had clear systems in place for the management of medicines. There was a system in place for ensuring a medicines review was recorded in all patients' notes for all patients being prescribed four or more repeat medicines. We were told that the number of hours from requesting a prescription to availability for collection by the patient was 48 hours or less (excluding weekends and bank/local holidays). The practice met on a quarterly basis with the Medicines Manager and Clinical Commissioning Group (CCG) pharmacists to review prescribing trends and medicines audits.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We reviewed the doctor's bags available to GPs when doing home visits and found they did not routinely carry medicines for use in patients' homes and there was no risk assessment in place to support this decision.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, the prescribing of medicines to patients in a nursing home setting.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had the equipment and in-date emergency drugs to treat patients in an emergency situation. We saw that emergency medicine, including medicines for anaphylactic shock, were stored safely and were monitored to ensure they were in date and effective. These medicines were monitored for expiry dates and records were kept of this.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were

able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the local Clinical Commissioning Group (CCG) had undertaken an infection control audit of the practice. The results showed 99% compliance for the practice. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this such as risk assessments for staff using display equipment. Building risk assessments were in place and records to show the mitigating actions that had been put in place.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

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

The practice had carried out a fire risk assessment in 2013 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines however, we considered improvements were needed to ensure all GPs were consistent in their application of the guidance.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

We found that clinical audits were carried out in an ad hoc basis. The lead GP confirmed to us the practice was aware of this but because of senior partner changes this area of work had lapsed. We did see a completed and full audit for looking at the management of patients with Coeliac disease to determine if guidelines were being followed. This identified the practice needed to make a number of improvements to the care and treatments they provided and an action plan was put into place. Other audits we saw were linked to medicines management information, or as a result of information from the quality and outcomes framework (QOF).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 99.6% of the total QOF target in 2014, which was above the national average figures. Specific examples to demonstrate this included performance for asthma, kidney disease, dementia and chronic obstructive pulmonary disease (COPD) where the

Good

Are services effective?

(for example, treatment is effective)

practice achieved 100% of the total point available. The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of clinical audit tools, supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. However formal all practice meetings were not taking place. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures, for example Number of antibacterial prescriptions issued was within national limits. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had completed the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and those with mental health conditions. Structured annual reviews were also undertaken for these patients and those also with long term conditions such as COPD and heart failure. The QOF data showed good performance in all of these areas.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with some number having additional diplomas in areas such as dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurses were soon to undertake a nurse prescribing course to support them in their roles.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties, for example the administration of vaccines and cervical cytology. Those with extended roles such as the management of chronic disease management were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on

Good

Are services effective?

(for example, treatment is effective)

the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively high at 19.4% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice worked closely with other health and social care providers in the local area. The GPs and the practice manager attended various meetings with management and clinical staff from practices across the CCG. These meetings were used to share information, good practice and national developments and guidelines for implementation and consideration.

The practice attended various multidisciplinary team meetings at regular intervals to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by community staff such as district nurses, health visitors, social workers and end of life care nurses.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed prior to consent being obtained for an invasive procedure. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for minor surgery a patient's written consent was obtained and documented.

Health promotion and 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 and information in the waiting area about the services available. The practice also provided patients with information about other health and social care services such as carers' support. Staff we spoke with were knowledgeable about other services, how to access them and how to direct patients to relevant services.

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering

Good

Are services effective?

(for example, treatment is effective)

additional help. For example, the practice kept a register of all patients with a learning disability they were all offered an annual health check. The IT system prompted staff when patients required a health check such as a blood pressure check and arrangements were made for this.

Patient and population group registers were in place to enable the practice to keep a register of all patients requiring additional support or review, for example patients who had a learning disability or a specific medical condition such as diabetes. Practice records showed that those who needed regular checks and reviews had received this and the IT system monitored the progress staff made in inviting patients for their annual health review. This included sending letters and telephone calls to patients to remind them to attend their appointments. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for the cervical screening programme was 84%, which was in line with the England average of 81.%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national patient survey and the practice own survey of patients which received response from 100 patients. The NHS England GP Patient Survey, published on 8 January 2015, gives more up to date information on the service provided by the practice. Data for this survey was collected between January and March 2014, and July and September 2014. The results showed that patients described their overall experience of their GP surgery as fairly good or very good, the figure was 91% compared with 85% nationally. The proportion of respondents to the GP patient survey who 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 was 96% compared with 85% nationally. Patients said the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care, the figure was 82% compared to 85% nationally.

During our inspection we spoke with two members of the Patient Participant Group (PPG). They told us the practice worked closely with their group to develop the services for the practice patients. The practice had reported to them the results of their patient survey which had been carried out in December 2014. Patients shared their views on how helpful staff were, privacy and overheard conversations at the reception appointment times and long waits when seeing the GP. We saw an action plan had been put into place to address these patient comments.

We received 15 Care Quality Commission (CQC) comment cards which patients had completed before our inspection. Eleven of the comments made were positive including how caring staff are, how supportive they care and how the environment is clean and tidy. Four cards gave negative comments and these related to poor staff attitude and the lack of availability of GP appointments. We spoke with six patients in total, throughout the morning and in the afternoon. Those we spoke with told us of the caring, supportive and friendliness of the staff and their confidence in the GPs and nurses at the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. The patients we spoke to said they were satisfied that GPs and nurses involved hem in their care. The proportion of respondents to the GP patient survey who 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 was 96% compared with 85% nationally. Patients said the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care, the figure was 82% compared to 85% nationally.

Good

Are services caring?

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example their own patient survey has raised concerns about patient appointments and this was in constant review by the practice.

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included concerns raised by the group relating to improvements needed to the entrance of the building. Appropriate actions and changes to the entrance were made upon their suggestions. The practice been proactive in the developments made to the patients website in discussion with and from feedback form the PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Patients with multiple conditions were offered more time during their appointment or annual review so they did not need to attend the practice for individual medical conditions. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. However the disabled and mother and child toilet did not have a wide door which made this are inaccessible for some patients. The practice were aware of this and had undertaken a risk assessment of the area.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

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

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday. The practice has appointments from 8am on a Monday, and until 7.30pm on Tuesday and Wednesday evening. The patients also had access to another practice, Bath Street in Warrington for extended hours (6-8pm) each day.

We spent time in the patient waiting room and spoke with patients about their views and experiences. The room was bright and had adequate space, the reception area was open plan and reception staff tried to respect patient confidentiality during conversations. Generally the area was large enough to meet the patient demands during our inspection. The area had reading materials such as magazines. The walls displayed patient information and patient leaflets were available making this an accessible and comfortable area for patients to wait for appointments.

The receptionists had a pleasant and helpful manner both in their interactions with patients attending the practice and during telephone conversations. Patients we spoke with and the comments card we received during the inspection told us getting an appointment was good and if

Good

Are services responsive to people's needs?

(for example, to feedback?)

needed, they would always be seen on the same day. They also said they could see another doctor if there was a wait to see the doctor of their choice. The national GP patient survey reported that 73% of respondents found it easy to get through to this surgery by phone and 86% of respondents find the receptionists at this surgery helpful in this process. The results showed that 86% of patients were able to get an appointment to see or speak to someone the last time they tried and 96% say the last appointment they got was convenient.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, children who required an urgent appointment were seen the same day.

The practice had a website which displayed information for patients on a range of subjects including, opening times, the clinics available, general information about the practice including photographs of the GPs and the practice. The web page provided advice to people about health campaigns such as their flu campaign and how to access services. In addition, the website served as the gateway to the practice's online facilities, including appointment booking and repeat prescription services.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This included patient's posters and complaints information leaflets. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found and found that timely and appropriate responses had been made. We were clear that listening and learning had taken place following a patient complaint but there was insufficient evidence to show that action plans were put into place to prevent the complaint happening again.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and patient and staff information. The lead GPs were aware the vision had been written some time ago and a review date was planned in the near future. The practice vision and values included their aim to provide holistic care, to provide appropriate care and support when needed by patients when ill and in times of difficulty.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken, however this was implemented in an ad hoc manner and required improvement. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example on-going environmental risk assessments. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. This included newly recruited staff who spoke positively about their induction process. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice, the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every weekly but that not all staff attended a formal regular meeting. Notes were made of the meeting and these were passed to staff for their awareness but they did not have the formal opportunity to raise their issues and concerns during a staff meeting. Staff told us however, that there was an open culture within the practice and they had the

Are services well-led?

Good

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

opportunity to raise any issues and confident in doing so and felt supported if they did. We also noted that team away days were held quarterly. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups, this included younger members which was reflective of their local population. We met with two members of the PPG and they spoke positively about how the group was supported by the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We heard how a number of community events had taken place to engage and involve the local community. The group had a 'tea party' planned for the summer to encourage older members of the community and those isolated patients to attend the practice to raise awareness of the service they can access. Both these examples were good examples of how the PPG and the practice were reaching out to the local population and those hard to reach groups to ensure their health needs were met. We saw evidence that the practice was actively encouraging patients to be involved in shaping the service delivered at the practice and the PPG was a key part of this work. This included contact with the local secondary school to ensure younger people were given the opportunity to give their views of the practice and how it should be developed to meet their needs.

We saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing.

The practice had gathered feedback from staff on an informal basis and formally during regular staff meetings. However practice staff meetings did not routinely include reception and administration staff so there was less opportunity to get their feedback in a formal way. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was an open and no blame culture and staff felt supported to raise concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Staff had access to a programme of induction, training and development. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff were supervised until they were able to work independently but written records of this were not kept.

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