Greenbank Surgery

Quality Report

274 Manchester Road
Warrington
WA1 3RB
Tel:
01925 631132
Website:
www.greenbanksurgery.com

Date of inspection visit: 21 May 2015
Date of publication: 30/07/2015

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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Greenbank Surgery on 21 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services, with outstanding leadership. The practice was good for providing services for older people; people with long term conditions; families, children and younger people; working age people and people experiencing poor mental health including dementia. The practice provided outstanding care and treatment for those people whose circumstances made them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns. Safeguarding systems were well developed; GPs had strong working links with child health teams and child protection teams. Safeguarding records were detailed, comprehensive and were shared appropriately and in a timely manner.
- Practice partners extended the scope of learning for all GPs by requesting reports or information from coroners on the cause of unexpected deaths.
- Patients' needs were assessed and care was planned and delivered following best practice guidance; where any change of medication was recommended, each patient's need was considered individually.
- Patients said they were treated with compassion, dignity and respect.
- Patients told us it was easier to make an appointment with a named GP, since the practice had made staffing changes. Patients said there was more continuity of care, with urgent appointments available the same day. Changes made to the staffing of the practice had resulted in 100 extra GP appointments each week, demonstrating that the practice was responsive to patients' needs.

Summary of findings

- The practice partners had invested in the development of facilities at the practice, which was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. We saw evidence of audit driving improvements in services offered to patients. The practice leadership reviewed workloads of all clinicians and support staff, ensuring that demand was manageable and that patients were attended to by clinicians that were sensitive, focused and responsive to patient needs.

There was also an area of practice where the provider could make improvements.

In addition the provider should:

- Decommission an old air conditioning system in the data/server room of the practice.

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 were clear on their responsibilities to report, record and investigate incidents. Staff of all levels regarded patient safety as a priority. Staff felt confident about approaching leaders to report and record any incident or concerns. Investigations were thorough; lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. GPs were committed to the protection of children and vulnerable adults.

Are services effective?

Good

The practice is rated as good for the provision of effective services. Patient's needs were assessed and care was planned and delivered in ways that met their needs. This included assessing capacity and promoting good health. The practice kept lists of patients who required regular health checks, and these appointments were delivered by the practice nurse. The practice GPs engaged with other clinicians to ensure that patients discharged from hospital received the follow-up care they needed.

Are services caring?

Good

The practice is rated as good for providing caring services. We spoke with six patients on the day of our inspection, who told us they rated practice staff as very caring. CQC comment cards that patients used to record their views of the service reflected this. Data from the latest GP Patient Survey, published in January 2015, gives findings for data collected between January and March 2014 and between July and September 2014. For this survey, 311 questionnaires were distributed. Less than half (128) forms were returned. This represents a response rate of just 41%. The practice scored highly on questions asked about whether GP's gave patients enough time (87%) and whether a patient's GP was good at listening to them (90.9%). Where scores were lower, for example in response to questions asked about

Summary of findings

whether the nurse was good at involving patients in decisions about their care (62.5%), this score was in line with the average for other practices in the area (64.6%), and with the England average (66.2%).

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice partners had completed a comprehensive analysis of patient demand for appointments, and reviewed this in line with patients health needs. Access to nursing staff for management of conditions, minor ailment clinics and medication reviews were also considered. The results enabled the practice to restructure the make-up of the partnership, advertise for and recruit two salaried GPs, two nurse practitioners and a health care assistant. The net result of this has been an increase of 100 extra GP appointments available to patients each week, and the new nurse practitioner running the daily "open surgery" for which no appointment is needed. The nurse practitioner consults with patients all day long. The practice is looking to extend this service further, when the second nurse practitioner returns from a period of parental leave. The increased scope of duties for the healthcare assistant has left the two practice nurses and the treatment room nurse, greater time to manage patients' chronic illnesses and long term conditions. Review of the most recent Family and Friends Test responses shows that patients have appreciated the steps the practice has taken to meet their needs.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. Staff spoke of an open door policy at the practice, and told our inspection team that they felt comfortable about approaching leaders to raise any concerns. We saw how management and staff reported any performance issues and that these were dealt with quickly and appropriately. All staff were allocated protected learning time and training that enabled them to deliver their duties effectively and safely. The practice was also a training practice, hosting medical students and GP registrars. Leaders were visible, supportive and inclusive of all colleagues, promoting strong team working both within the practice and externally. The practice was also part of a federation of six practices in the area. This meant that

additional services could be commissioned. The practice leaders had conducted evaluation and review exercises on how they provided services to patients. As a result they made significant changes to how the practice was run, which had benefitted patients in terms of access to services. These changes also helped protect clinicians from common causes of fatigue and ‘burn out’.

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. All older patients were assigned a named GP. If older patients were admitted to hospital in an unplanned way this was reviewed by the GP and if required, changes would be made to their treatment plan for example a change in medicines. Health promotional advice and support was given to patients. This included signposting older patients and their carers to support services across the local community. Older patients were offered vaccines such as the flu vaccine each year. An indicator of the level of service provided by the practice was that the practice supported all nursing homes within the local area, although this was not a contractual obligation.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The appointment of two Nurse Practitioners, who worked closely with the practice nurses, meant that patients with longer term conditions and chronic illnesses had good access to clinical support. All patients with a long term condition were offered either annual or six-monthly health checks. Our review of referrals for these patients and their treatment pathways demonstrated that treatments were delivered in line with best practice. The practice had reviewed its patient register to ensure patients who were more vulnerable to unplanned hospital admission, had a care plan in place which was regularly reviewed. Where a patient was supported by a carer, these were involved in updates to the care plan and details of any medication changes.

Families, children and young people

Good

The practice is rated as good for services to families, children and young people. Arrangements were in place to ensure that the lead safeguarding GP at the practice, conducted six week checks on all new born babies. This GP also maintained contact with community based health visitors to ensure new mothers attended the practice for all baby immunisations and vaccinations. The practice had liaised with the midwife that visited the practice, to alter the times of ante-natal clinics, which involved the midwife working later to meet the needs of working mothers-to-be. The open access appointment service meant patients who needed to see a GP on the day, would be seen. This was particularly commented on by those patients we were able to speak with, who were parents of very young children.

Summary of findings

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 practice had plans to develop the scope of duties of the two Nurse Practitioners, to include fitting of contraceptive implants and coils, making these services more accessible to patients. The practice was due re-start its minor ailments clinic, which had stopped when two of the practice partners retired and a practice nurse had left. The recruitment of an additional permanent salaried GP meant that appointments were available from 8.00am in the morning until 6.30pm in the evening. A late surgery was offered on a Wednesday evening, when patients could be seen up to 8.00pm. Any patient requesting an appointment, who couldn't be accommodated by the practice on that day, would be offered an appointment at a neighbouring surgery, under the Warrington Health Plus Extended Access Service. This provided patients with GP services outside of practice appointment times, between 6.00pm and 8.00pm and from 8.00am to 8.00pm on weekends.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances make them vulnerable. The practice supported patients who lived at a local women's refuge. Staff ensured that if patients from the refuge attended the open access surgeries, they were not turned away and that any children were seen 'on the day'. The practice had recently been audited by a service for deaf people, and scored highly for the way in which deaf patients were responded to and how it met their needs. Patients could be seen with an interpreter of British Sign Language, or with their own carer acting as a translator. We saw that the practice had very strong governance systems in place to ensure that any vulnerable patient, adult or child, who was subject to a safeguarding plan, was seen by a named GP who was the safeguarding lead for the practice. Any non-attendance was followed up and updates communicated quickly to all colleagues, internally and externally. We found safeguarding records were comprehensive, up to date and that incoming information was added to existing records as a priority by support staff. The practice also ran a service for patients excluded from other practices due to threatening or violent behaviour. Again the practice kept sufficient records to ensure that any risks associated with the provision of this service were assessed and minimised.

Summary of findings

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 those living with dementia. The practice had recently reviewed the way it cared for and engaged with patients with poor or deteriorating mental health, including with patients who had dementia. The practice had a GP whose area of specialist interest was dementia; all staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Nurse practitioners at the practice were involved in assessment of capacity before delivery of some elements of care and treatment, for example examination and administration of injections. The practice had recently undergone a significant upgrade to its premises, which provided further treatment and consultation rooms. As a result of this, plans were in place to host additional services, provided by the community Mental Health Team.

Summary of findings

What people who use the service say

We received nine Care Quality Commission (CQC) comment cards which patients had completed before our inspection. Seven cards gave positive comments about the service. Two cards gave neutral / negative comments around waiting times when arriving at the practice. We spoke with six patients during the inspection. Patients we spoke with told us of the dedication, friendliness and compassion of the staff, and the quality of service provided by the GPs and practice nurses. Patients commented particularly on the recent upgrade to the building. We spoke with members of the practice Patient Participant Group (PPG). They told us GPs and staff valued their opinions and feedback, explaining how they were invited to help with mystery shopping exercises and feedback from patient surveys. The outcome of the last survey carried out by the practice for the year 2103-14, rated the service as good overall. Issues identified by patients as requiring improvement, were the speed of access to the practice by telephone, and how calls were managed by the system currently in use. The practice reported back to patients and the PPG that the cost of replacement or upgrade of the telephone system at this time would be prohibitive. This was due to the contract for the service and equipment having a significant time left to run.

The NHS England GP Patient Survey, published on 8 January 2015, gives more up to date information on the service provided by Greenbank Surgery. 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, when asked, 90.9% of patients said the GP they saw was good at giving them enough time when in consultation. The average for the Warrington Clinical Commissioning Group area was just 88.4%, and the England average was only 87.2%. When we asked the practice why they thought this was, we were told that appointment times had been extended to 12 minutes per booked appointment, to allow patients 'travelling time' - time to walk from the waiting area to the consulting rooms, following the recent refurbishment of the building. This small change by the practice had resulted in higher patient satisfaction with their GP consultations. When asked, 93.1% of patients said they had confidence and trust in the GP they spoke with. The average score for practices in the CCG area was 92.8% and 92.2% across England. When asked, 90.9% of patients said their GP was good at listening to them. Warrington CCG average score was just 88.4%, and across England, just 85.3%.

Patients we spoke with included older people, parents with young children, patients who were carers or otherwise employed and those with long term conditions and those recently retired. All patients said the service from the GPs, nurse and staff was very good.

Areas for improvement

Action the service SHOULD take to improve

In addition the provider should:

- Decommission an old air conditioning system in the data/server room of the practice.

Outstanding practice

- The practice demonstrated outstanding leadership in its vision of how care and treatment should be delivered, and took practical steps to achieve this.
- When the practice reviewed its structure and staffing, it took account of the needs of patients, whilst allowing clinicians sufficient time for continuous professional development.
- All decisions were aligned to the practice business plan, which was reviewed throughout the year. All staff were committed to achieving the vision and aims of the practice.

Greenbank Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Adviser and a Practice Manager Specialist Advisor.

Background to Greenbank Surgery

Greenbank Surgery is located in Warrington, Cheshire. The practice is run by four GP partners and services are delivered under a General Medical Services (GMS) contract.

The practice partners employ two salaried GPs, two nurse practitioners, three practice nurses, a healthcare assistant and pharmacy advisor. The practice is supported by a team of 12 administrators and receptionists, and a buildings caretaker/manager.

The practice is a training practice, hosting medical students in their fourth year of training and qualified doctors who are undergoing GP training – GP registrars. The patient register stands at 9,200 patients. Pre-bookable appointments are available each morning and afternoon up to 6.30pm. The practice also runs open access appointments during the morning, between 8.00am and 10.00pm, for patients with urgent problems. Under this system, patients can attend the practice before 10.00am, and will be seen by either a nurse practitioner who is able to prescribe medicines, or a GP. Where any patient cannot be seen by the practice, and has been triaged by the nurse practitioner or GP as requiring a GP appointment, they can be referred to a GP service held locally, that accepts 'overflow' from neighbouring practices. This is a temporary arrangement supported by finance from the Prime Ministers Challenge Fund.

The normal opening hours of the practice are from 8.00am to 6.30pm in the evening. Extended hours appointments are offered until 8.00pm on Wednesday of each week. Outside of these hours the practice will divert patients that phone the practice to the out of hours service commissioned by Warrington CCG. The practice does not close at lunch time, but is closed on the last Thursday of each month for staff training.

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 May 2015. During our visit we spoke with a range of staff including three GP partners, the practice manager, a practice nurse and a nurse prescriber. We also spent time talking to the Patient Participation Group and six patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 where aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice manager kept all practice colleagues up to date with health and safety information and identified any action that needed to be taken to ensure patient and staff well-being. For example, the practice had an air conditioning unit located in a store room on the first floor. This was out of use and all staff had been briefed by the practice manager that it was not to be turned on. The practice manager had contacted Warrington Clinical Commissioning Group and the landlord of the building, to organise the professional decommissioning of the unit.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. We reviewed records of significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events. Recently, the practice made the decision to review past significant events on a six monthly basis, to allow closer scrutiny of incidents for any common themes, and to be able to respond quickly were this was required. In these meetings, action points were made in response to any findings. For example, the GPs, wider clinical team and the practice manager noted that they were not routinely sent copies of coroner's reports, in cases of unexpected deaths. The practice had put arrangements in place to request these, and to review findings to see if any more could have been done by the practice to prevent and unexpected death, and to apply learning for the whole team wherever possible. Whilst this was valuable to all in the clinical team, it presented a particularly good opportunity for insight by GP registrars and medical students, working at the practice.

Reliable safety systems and processes including safeguarding

The practice had systems in place to identify, highlight, track and record all safeguarded children and vulnerable adults. A partner at the practice acted as the safeguarding lead, with a second partner acting as their deputy. All GPs at the practice were trained to the required level in safeguarding (Level 3). The safeguarding lead had worked closely with the Child Health Team and Child Development Centre, to receive updated lists on at least a monthly basis, to cross check practice records against those shared by these two teams. The safeguarding lead had also developed strong working relationships with community health visitors, community midwives and social workers. All information on how to contact these professionals was up to date and immediately available to all clinicians at the practice. The safeguarding lead maintained a RAG rated register of vulnerable and safeguarded patients. This identified patients, using a traffic light system of red, amber and green status. Red denoted children or vulnerable adults subject to a safeguarding plan. Amber indicated those patients who had been on a safeguarding plan, but had been 'stepped down' from this, for example, looked after children and children in need. The IT system used by the practice allowed a patient footprint to be left by any safeguarding action in the past, and these were the patients denoted as green in the RAG rated system. Staff had all received safeguarding training and understood their role in ensuring that correspondence in relation to any safeguarded patient was to be brought to the attention of the safeguarding lead. In one example we saw how a hospital letter delivered to the practice, gave details of a safeguarded child that had very recently registered at the practice. This meant that patients were made known to the practice almost immediately. The safeguarding lead at the practice was responsible for conducting all new babies six week health checks. The complex nature of families and their relationships was understood by this GP, which informed their vigilance.

There was a chaperone policy in place at the practice. This service was advertised on waiting room noticeboards, 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. All staff undertaking chaperone duties had undergone Disclosure and Barring Service (DBS) checks.

Good

Are services safe?

(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

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures. Records showed fridge temperature checks were carried out which ensured medication was stored safely.

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 regulations. For example, we saw that a medicine called Tramadol, which required secure destruction and disposal, was dealt with by a nurse at the practice and witnessed by another clinician or the practice manager. This was also recorded in a central log by the practice.

The practice had reviewed systems to ensure medicines prescribing was done in the safest environment possible. For example, the practice had updated its policy on remote prescribing, to inform all clinicians that prescriptions were to be completed when back at the practice. This meant software on the practice system could give an alert if there are indications a medicine may not be suitable for a patient, reducing the possibility of errors in prescribing. The GPs could then arrange for the prescription to be sent to the pharmacy of choice of the patient, meaning there was no delay in treatment for patients.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. The practice had recently taken on a pharmacist to help the practice review prescribing. For example, at the time of our inspection, the pharmacist was reviewing the prescribed medicines of all patients over the age of 75 years.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

We observed the premises to be very clean and tidy. Cleaning schedules where 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 was in place and staff were able to refer to this. We saw that 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. A policy for needle stick injury was in place and nurses and other staff knew what steps to take in the event of an injury. Spillage kits for clearing spills of bodily fluid were available in reception areas and treatment rooms. All staff knew how these were to be used, and could refer to training updates they had had, in respect of this.

The practice had recently undergone a programme of upgrade and refurbishment. As a result of the work, there were 12 consulting/ treatment rooms used by clinicians. Two of the rooms required upgrades to sink units although this did not mean they couldn't be used safely. All flooring and work surfaces in treatment rooms met infection control standards required of GP practices. All rooms were well equipped; we saw that cleaning schedules were in place for all rooms and equipment. 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.

One of the practice nurse's was the lead for infection control, and we saw that a deputy was appointed to oversee this work when required. From records available and visual checks of clinical, waiting and reception area, we saw that infection control was well managed at the practice.

The practice manager had carried out a risk assessment in respect of testing for the presence of Legionella bacteria. The risk assessment deemed that this was not necessary. This had been re-visited recently to take account of an old air conditioning unit in a first floor room at the practice. The purpose of the unit had been to cool the room and remove heat generated by IT servers and related equipment. Since the upgrade to the building and IT systems the air conditioning unit had not been used and staff didn't enter this room. This was covered in the risk assessment; all staff had been informed it was not to be

turned on and staff were not to use this store room. The landlord of the building and the local CCG were meeting in June 2015 to arrange professional decommissioning (removal) of the unit.

Equipment

The practice told us that all equipment was tested and maintained regularly. The practice manager was able to show us a register of all equipment, which room it was located in, and maintenance logs and other records that confirmed this. Servicing contracts were in place for all equipment used for measurement and monitoring, for example blood pressure cuffs and weighing scales. We saw that all equipment of this nature had been tested and calibrated in March 2015, and reminders were in place for re-testing and servicing each year thereafter. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was in November 2014. We saw that all portable electric equipment was itemised in a register, with dates identified for re-testing.

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).

Where any GP was employed from overseas, the practice manager had requested copies of visa's and made checks to ensure the visa allowed GPs to work without limitations in the UK.

Practice partners and all other clinicians had a rota system in place to ensure that enough clinicians were on duty, and the skill mix was sufficient to meet the needs of the patient population. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. When we reviewed staffing and work patterns, we saw that there were sufficient staff in place to ensure patient safety, and that GP registrars and medical students were adequately supported.

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 and dealing with emergencies and equipment. Staff received training updates annually on health and safety.

The practice had previously used locum GP's, before the partnership was restructured. Due to an instance where a patient had been unhappy with the treatment received from a locum GP, the practice reviewed all patients who had been consulted with by the locum. Findings were shared with the agency that provided the locum and records kept of this. Since the restructure of the partnership, the policy of the practice is to provide cover for annual leave of GPs and other absences, from within. We saw that there was sufficient flexibility within the clinical team to facilitate this.

The practice provided services for those patients that had been excluded from other practices in the Warrington CCG area, due to their unpredictable or volatile behaviour. The practice manager and staff had conducted regular risk assessments in relation to each patient. This included review of records for an accurate picture of any triggers of challenging behaviours. Precautions were taken to mitigate risk, for example patients accessed the practice through an alternative doorway, were offered 30 minute appointments, and if necessary shown to a quiet waiting area, away from the bustle of the main reception area. Wherever possible these patients were allocated an appointment with a GP they knew and had seen before. From review of significant events over the past 12 months, we could see that the scheme was well managed and that no incidents had occurred at the practice involving these patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was

Good

Are services safe?

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 how to access these medicines. Emergency medicines included those for the treatment of heart problems, anaphylaxis and hypoglycaemia. Antibiotics were also kept for use in an emergency, for example, potential cases of childhood meningitis. 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The practice was part of a federation of five other practices. The business continuity plan also contained relevant contact details for staff to refer to, for example details of key holders and who to contact at other practices for support in event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All patients who registered with the practice were offered a new patient health check. This could be conducted by a nurse if the patient had declared that they had long term conditions, such as diabetes, asthma or other respiratory diseases. Where necessary, patients were added to registers to ensure that their condition was regularly monitored by the practice nurses and GPs.

GPs and nurse practitioners at the practice could clearly explain their assessment of patient's needs, and how this related to National Institute of Health and Care Excellence (NICE) guidance. Treatment of patients followed this guidance and the prescribing protocols of the local Clinical Commissioning Group (CCG). We saw minutes of practice meetings where new guidelines were disseminated and discussed. If any patient treatments did not follow guidance, the rationale and explanation for this was clearly documented in patient records.

Management, monitoring and improving outcomes for people

GPs and nurses at the practice regularly met to discuss patient outcomes, using a number of data sources as reference points, for example, data taken from the Quality and Outcomes Framework (QOF). We saw several examples of review of patients by the nurses. One review was carried out of patients with a diagnosis of asthma who were receiving medicines for this, but not attending regular check-ups with the practice nurse to ensure their health needs were being correctly treated and managed. By conducting reviews, patients' conditions were managed well and up to date information was provided on how to treat any exacerbation of their condition, for example, by issuing emergency rescue packs. These contained medicines which patients could use in the event that their condition deteriorated, and in some cases when taken early enough, could prevent unplanned admission to hospital. Data made available to us during our inspection showed those patients with long term conditions were being regularly seen by practice nurses, nurse practitioners and GPs, and that their medication reviews were done in a timely fashion. Some audits we reviewed were triggered by the medicines management team of the CCG. For example, the prescribing of antibiotics. In some ways, this linked to treatment of patients with respiratory illnesses. Antibiotics were included in rescue packs, and as these patients had been reviewed systematically by practice nurses and nurse practitioners, and issued with rescue packs, the number of antibiotics prescribed, had risen. The clinical team explained they would look to data relating to unplanned admissions of these patients, to gauge if the review of patients and medicines had reduced those unplanned admissions.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits we reviewed included an audit of patients treated for bone fragility, an audit of patients over the age of 90 years, and an audit of patients treated for respiratory infections. Two of these audits had been through two complete cycles, with conclusions drawn and any learning points identified. When learning points were identified, these were shared within the practice and at cluster meetings of other practices in the area. The audit of patients treated for bone fragility was due to go through a second cycle at the end of May 2015.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with mandatory training such as basic life support and safeguarding training. We noted a good skill mix among the doctors at the practice who also had areas of specialist interest, for example sexual health, dementia, and cancer and palliative care. Plans were in place to train the nurse practitioners to fit contraceptive implants. 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; any learning needs identified where included in objectives set for the following year. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, further training of nurse practitioners for fitting of contraceptive implants. As the practice was a training practice, GP registrars were offered extended appointments and had access to a senior GP throughout

Good

Are services effective?

(for example, treatment is effective)

the day for support. Medical students were also well supported; we saw from staff planning documents that senior partners were always on duty when medical students and GP registrars were at the practice.

Working with colleagues and other services

We saw several good examples of how the practice worked with other services to achieve the best outcomes for patients. The practice had worked collaboratively with five other practices to set up an intermediate care facility. This facility acted as a 'step up/step down' unit which accommodated those patients, many of them older, who could be discharged from hospital but would require a short period of extra support before being sent home. Similarly, where a patient required some extra support through a period of debilitating illness they could be cared for by the facility for a few days, rather than being admitted to hospital. This unit was supported by GPs drawn from the five practices working on the project, and acted to keep patients well enough to live at home, rather than be admitted to hospital.

The practice had systems in place to manage all incoming correspondence. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the follow up action required, and we saw that the workflow and tasking system in place worked well. Staff understood their responsibilities in relation to the safe handling of patient data and correspondence. The practice manager had taken steps to manage any backlog of summarising of patient notes. (Patients' records and notes are reviewed and summarised when entered onto the computer system of the practice they register with.) Some work in this area had built up, but simple contingencies put in place by the practice manager had worked well in managing and addressing this.

The practice held multidisciplinary team meetings to discuss patients with complex needs. Examples of minutes we reviewed included meetings in respect of people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We particularly noticed the amount of work the practice had contributed to, in relation to safeguarded children and adults, particularly those patients with complex learning disabilities.

Information sharing

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.

We saw that staff recorded and reported any delay in receiving information from out of hours care providers. Also, staff reported regularly to the practice manager, the level of patient notes summarising that was waiting to be done. In cases such as this, staff ensured the information from a patient summary record was uploaded to the electronic system, giving GPs access to the most recent case notes and details of medications in use. Any information on safeguarding was also captured and added to the system.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and Gillick competence. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. We asked for examples of how patients from these two groups (those with a learning disability and those with dementia) were supported to make decisions. In a case of an older patient with a learning disability, we saw how staff enabled them to live as independently as possible within the community, which was their wish. To achieve this, they provided a patient with an 'insulin passport'. This identified the patient as being diabetic, had instructions in relation to their insulin dosage in large print, and information for other people should the

Good

Are services effective?

(for example, treatment is effective)

patient require their help. In a case involving a patient with dementia, staff in a nursing home explained that the patient would become confused or agitated and try to stand unaided. This resulted in the patient experiencing falls. The GP concerned held a 'best interests' meeting, inviting all persons involved in the patients care, including family members. The GP confirmed that an up to date mental capacity test had found the patient had limited capacity to consent. The best interest meeting looked at the least restrictive option for keeping the patient safe, which could be reviewed over time. A lap belt was provided which would prevent the patient from standing, unaided. All details of this were recorded in patients notes and dates set for review.

We saw that the practice GPs and nurses recorded consent decisions within consultations. For example, when fitting contraceptive implants or delivering injections, consent forms were signed by patients. Clinicians and the health care assistant also recorded implied consent, for example, when collecting blood for testing.

Health promotion and prevention

All new patients who registered with the practice were offered a new patient consultation. Patients who declared on their registration form that they used regular medication or had a long term health condition, were seen by a nurse practitioner or practice nurse. Other patients, who declared no longer term health condition, could be seen by the health care assistant. Within these appointments, other screening checks may be performed, for example, blood pressure checks and recording of patient's weight. Arrangements for other health promotion and advice would also be made, for example, referral to smoking cessation clinics or alcohol awareness sessions.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 97.5% of patients in this age group took up the offer of the health check. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled. Within the federation, the practice was the highest performing for engaging its patients and their attendance at these health checks.

The practice's performance for the cervical screening programme was 78.92%, which was in line with the England average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. We noted that figures for the percentage of patients aged 75 years and over who were treated with a bone sparing agent (given to patients who had experienced a bone fracture), were lower than the England average. The practice rate of treatment was just 60%, compared to the England average rate of 81.29%. However, the practice had conducted an audit which included these patients and pointed to their treatment pathway which is currently being monitored and reviewed. This demonstrated the practice commitment to evidence based treatment of patients, which would be reviewed in a systematic way.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed data available for the practice on patient satisfaction. This included information from the NHS England GP Patient Survey, and from the NHS Family and Friends Test. Data in respect of the Family and Friends Test was available from its implementation in March 2015. Data from the NHS England GP Patient Survey was gathered between January and March of 2014, and July and September of 2014. Results were published in January of 2014. We reviewed comments left by patients on CQC comment cards, in the two weeks before our inspection.

Data from the Friends and Family Test showed patients would be highly likely, or likely to recommend the practice to family and friends. Just three responses were neutral, saying patients would be neither likely nor unlikely to recommend the practice.

Data from the NHS England GP Patient Survey gave more detail and showed the practice performed well, being in line with or above the level of positive responses given at other practices in the area and with the England average. For example, when asked, 90.9% of patients said the GP they saw was good at giving them enough time when in consultation. The average for the Warrington Clinical Commissioning Group area was just 88.4%, and the England average was only 87.2%. When asked, 93.1% of patients said they had confidence and trust in the GP they spoke with. The average score for practices in the CCG area was 92.8% and 92.2% across England. When asked, 90.9% of patients said their GP was good at listening to them. Warrington CCG average score was just 88.4%, and across England, just 85.3%.

CQC comment cards completed by patients reflected the results outlined above; nine responses were left for us, seven of which were positive. More neutral comments related to waiting times when attending for an appointment at the practice.

We were able to speak to six patients on the day of our inspection. Patients told us they received a very good service and that they were treated with dignity and respect by all staff and clinicians. Patients said that GPs and nurses responded well to their health care needs.

Care planning and involvement in decisions about care and treatment

Information from the NHS England GP Patient Survey showed that when asked, 90.9% of patients said their GP was good at listening to them. Warrington CCG average score was just 88.4%, and across England, just 85.3%. Comments left by patients on CQC comment cards reflected this. Those patients we were able to speak to told us that they found GPs were very inclusive when discussing their treatment options. Patients told us they were given a choice of places they could go to, when needing treatment and that GPs gave them information on what waiting times were for each treatment centre. Patients said these were factors that were important to them.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the TV screen 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.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation or by advice on how to find support services. We saw evidence of support offered to patients, and how GPs had considered individual patients needs and the vulnerability of each patient. For example, in cases were older patients had lost their life partner.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice manager used the demand for open access appointments as an indicator of the need for more pre-bookable appointments, which allowed the practice to manage demand more effectively. Typically, any demand for more than approximately 28 open access appointments triggered the release of more pre-bookable appointments. One of the practice partners had conducted an audit on open access appointments which showed the reason for patients requesting to see a GP or nurse practitioner 'on the day' was not usually an urgent one, which supported the decision to open up more bookable appointments, reducing open access appointments.

The practice produced an action plan each year, detailing areas it wished to concentrate on and drive improvement. Sources drawn on to identify areas for improvement included feedback from patients in practice surveys and from the Patient Participation Group. An example of this was the plan to re-introduce the minor ailments clinic, which could be managed by the nurses and nurse practitioners. This would release GPs from routine appointments to enable them to concentrate on other areas of practice. Another example, following analysis of the number of requests for repeat prescriptions, was the employment of a pharmacist by the practice. This member of staff could review requests for repeat prescriptions and safely approve them. Also, this meant the practice could meet its commitment to provide repeat prescriptions within 48 hours of request.

Tackling inequity and promoting equality

The practice staff and management team worked well together to ensure the needs of all patients at the practice were met. For example, when the practice planned appointment times, it looked at what was the norm, what was aspirational, but also, what was practical and worked for patients. Since the refurbishment of the practice, the walk from waiting area to consulting rooms was longer, through a corridor and a series of fire doors. To accommodate this, GP's added onto the 10 minute appointment, two minutes travelling time, i.e. the time it took to walk from the reception room, through the fire doors and along the corridor to the GP's consulting room. The able bodied patients benefitted from this as they could complete the walk in less than two minutes. But for parents with toddlers, babies and pushchairs, and patients who could not walk as quickly, it meant the journey time did not impact on their time with the GP. Although this may seem a minor point, the practice was able to demonstrate that it recognised that any patient can be at a disadvantage, at various points in their life, i.e. parents with toddlers and pushchairs, or a very fit patient, recovering from a knee injury.

The practice provided services for a number of vulnerable patient groups, and kept registers of these patients to ensure they were offered annual or six monthly health checks. For example, those patients with a learning disability, those patients who were carers, or those patients living in vulnerable circumstances, such as the homeless or people living in hostels. We saw in all cases that access to services for these patient groups was good. The practice manager explained that even when their patient list had closed for a short period, they never turned away a vulnerable patient.

Access to the service

The practice opening hours were from 8.00am to 6.30pm, Monday to Friday. An extended hour's surgery was available on Wednesday of each week when the practice was open until 8.00pm. The practice did not close for lunch.

The practice had acted positively to feedback from patients on how they had found it difficult to get appointments, or to get through by phone to the practice. The practice had conducted a major review and restructure of the partnership and how services were provided. As a result of this, the practice now offers pre-bookable appointments on-line and ordering of prescriptions on-line. The practice partners had recruited a pharmacist who would help with review of prescribing but also review requests for repeat prescriptions, freeing GPs to do more patient focussed work. The practice is still able to offer open access appointments to patients who need to be seen on the same day; the practice confirmed it would always see any un-well child on the day if this was required. To achieve this, the practice had recruited two permanent salaried GPs, and a full time nurse practitioner who could prescribe

Good

Are services responsive to people's needs?

(for example, to feedback?)

across the BNF (British National Formulary). Originally the partners had planned to use the services of the nurse practitioner to cover for a nurse practitioner on leave. However, having seen the improvement in patient access this had facilitated, the partners plan was that the nurse would stay on, giving the practice two nurse practitioners'. These complemented the three practice nurses who led disease management clinics and provided treatment room services. The practice had also recruited a health care assistant who could assist in the work of the nurses. When we spoke with patients, all said that access to appointments was good and that they valued the service provided.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint and told us instructions on how to make a complaint could be asked for at reception. We noted that the leaflet provided to patients by staff, and freely available in the reception area, set out clearly how patients could make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We reviewed complaints received by the practice within the last 12 months. We noted that all had been responded to in line with the complaints policy of the practice. The practice conducted and annual review of complaints to detect any themes or trends. We looked at the report for the last review and no themes had been identified. However, any lessons learned from individual complaints had been shared with all staff and recorded in minutes of those meetings.

Are services well-led?

Outstanding ☆

(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 2015-16 business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice, to ensure that dates which goals should be reached by, were achieved. We saw that leaders addressed any reasons why goals had not been reached. Staff we spoke with understood the vision of the practice, and the role they played in achieving its aims and objectives.

Governance arrangements

There was a clear leadership structure in place at the practice, with named members of staff in lead roles. For example, there was a lead nurse for infection control; one of the partners was the lead for safeguarding, with another partner acting as a deputy. The practice lead partner had recently completed a course in Business Management and had applied their learning to the application of strong governance which supported the practice. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. The practice had a number of policies and procedures in place to govern activity and these were available to staff in electronic or paper format. Records kept showed staff were allowed time each year to refresh their knowledge on key policies. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held a series of meetings each month to ensure there was good communication between the practice staff and other community care providers. For example, there was a meeting for the partners every three weeks as a minimum, monthly staff meetings, clinical staff meetings and QOF (Quality Outcomes Framework) meetings. Meetings in respect of the care of palliative patients and Gold Standard Framework (GSF) meetings were held quarterly as a minimum and more frequently if required.

Leadership, openness and transparency

The practice staff spoke to us about the open door policy of the partners at the practice. The nurses told us they had good access to leadership and were well supported.

When we reviewed significant events, we saw that in cases where a patient was involved, the patient had been contacted by the partners and was informed of findings from the investigation into the event and offered an apology. All meetings with patients were recorded and linked to the significant event.

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. We saw examples of outstanding leadership at the practice, where decisions made supported the vision of the practice, to deliver person centred care of the highest quality. For example, two practice partners left the practice, one of these taking retirement on health grounds and leaving sooner than expected. The impact of this was that the practice did not have sufficient time to recruit two new GPs immediately, at a time when there was limited numbers of GPs available in the labour market to take up posts. Also, the volume and demand for patient appointments and the everyday work in general practice, meant the partners did not have time to dedicate to improving quality of patient care, but were left 'firefighting'. The practice monitored risks on a monthly basis to identify areas that needed addressing and took the decision to apply to NHS England to close its patient register, meaning it would not take on any new patients for six months. This allowed the practice to address the shortfall in appointments available to patients. To achieve this, the practice recruited two nurse practitioners, who were qualified to prescribe to patients. At the same time, the practice advertised for two salaried GPs. The decision to do this rather than recruit two new partners meant sufficient funds were available to keep both nurse prescribers on, on permanent contracts. The practice partners were open and honest with patients about the demands they faced, as they were with NHS England. As a result of these decisions the practice is now fully staffed; it continues to be a teaching practice, and has used the manpower it has available to develop services and plan for additional services, such as the re-introduction of a minor ailments clinic.

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

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

Are services well-led?

Outstanding ☆

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

by the practice to close its patient list for six months. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice, meeting with the Patient Participant Group (PPG) on a quarterly basis to discuss changes at the practice, for example, the ability to host additional patient services at its practice premises since its recent upgrade. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with 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).

Staff had regular meetings which were minuted; we saw that partners reviewed these minutes to ensure that any points raised were addressed by the management team. Although practice administrative staff had separate meetings from clinicians, we particularly noted there were no gaps in communication across the practice.

Management lead through learning and improvement

The practice was led by a management team that valued the services of all involved with the practice, and took active steps to protect the health and well-being of its staff.

In one example of this, we saw an audit conducted on stress levels of GPs and the effect of drop in clinics held by the practice. Conclusions drawn from the audit were that whilst drop in, or open access clinics were highly valued by patients, the practice had to draw a line under what was manageable and what was not. Using findings, the practice management team used the number of patients presenting for open access appointments, as a trigger point to convert more of those appointments to pre-bookable appointments, meaning no one GP would be expected to see more than 28 patients in a day. This resulted in a far more balanced clinic for all GPs, addressing some of the common causes of 'burn out'. The decision also helped staff working in reception areas and administrative support, as the levels of referral to secondary care (hospital) appointments, and other associated tasks which came from each patient consultation, was also more manageable. Managers had recruited additional administrative support staff to ease the workload of staff. We spoke with one of the newly recruited nurse practitioners. They told us they had talked with the partners about how their workload could reach very high peaks, and that the partners had reacted quickly to ensure they were supported to manage this. We found there were consistently high levels of constructive staff engagement; staff spoke of how proud they felt to be working for an organisation that valued their contribution. Staff said they felt motivated by leaders to succeed and to contribute positively to the success of the practice.