# Witton Street Surgery

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

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

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

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

- There were systems in place to protect patients from avoidable harm and abuse. Staff were aware of procedures for safeguarding patients from risk of abuse. There were appropriate systems in place to protect patients from the risks associated with medicines. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. We found improvements should be made to the records for staff recruitment.
- Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. We found improvements should be made to the records of staff training.
- Feedback from patients showed they were happy overall with the care given by all staff. They felt listened to, treated with dignity and respect and involved in decision making around their care and treatment.
- The practice planned its services to meet the differing needs of patients. The practice encouraged patients to give their views about the services offered and made changes as a consequence.
- Quality and performance were monitored, risks were identified and managed. The practice ensured that staff had access to learning and improvement opportunities.

We saw an area of outstanding practice:

# Summary of findings

- The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, one of the GPs was the Clinical Commissioning Group (CCG) lead for the IRIS programme (a general practice-based domestic violence and abuse (DVA) training support and referral programme). The GP lead was also involved in the training and raising awareness with all practices within the CCG area. Involvement in this programme had resulted in the practice identifying more patients at risk of domestic violence. The CCG had also identified the practice as being a high referrer for patients to gain support from other agencies to improve their health, safety and wellbeing. Reception staff were aware of the practice's involvement in this programme and ensured any patients who appeared to be distressed or injured were seen by a GP immediately. The GP lead for the programme ensured all clinicians had access to information leaflets to share with patients during consultations. The practice also supported partner agencies to access the practice to ensure vulnerable patients were seen in a safe environment.

**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 safe. There were appropriate systems in place to protect patients from the risks associated with medicines and equipment. The staffing numbers and skill mix were reviewed to ensure that patients were safe and their care and treatment needs were met. The practice was clean and there were systems in place to promote infection control. There were processes in place for reporting and investigating safety incidents.

**Are services effective?**

Good

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

**Are services caring?**

Good

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

**Are services responsive to people's needs?**

Good

The practice is rated as good for responsive. The practice planned and monitored its services to meet the differing needs of patients and identify priority service improvements. Access to the service was also monitored and changes made to meet patient needs.The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.

**Are services well-led?**

Good

The practice is rated as good for well led. There was a clear leadership structure in place. Quality and performance were monitored, risks were identified and managed. Staff told us they felt

# Summary of findings

| | |
|---|---|
| the practice was well managed with clear leadership from clinical staff and the practice manager. Staff told us they could raise concerns and felt they were listened to.The practice had systems to seek and act upon feedback from patients. | |

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. These included the avoidance of unplanned admissions scheme and a Vale Royal Clinical Commissioning Group (CCG) led initiative to improve care given to patients living in residential and nursing homes. The practice had a designated named GP for patients who are 75 and over, carried out home visits and had a rapid access appointment system.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. The practice had adopted a holistic approach to patient care rather than making separate appointments for each medical condition. Clinical audits were carried out to ensure patients were receiving optimal care, for example diabetes management.

The practice had achieved and implemented the Gold Standards Framework (to provide end of life care to ensure better lives for people and recognised standards of care) for end of life care. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. All new mothers were sent a letter advising them how to access mother and baby services. Staff prioritised appointments for children presenting with an acute illness. There was a system in place to follow up babies who had not been immunised and an escalation procedure to GPs if this remained a concern.

The practice offered family planning advice and services, offered free self-testing chlamydia test kits in the waiting area and provided an extensive range of sexual health information.

Staff were knowledgeable about child protection and a GP took the lead for safeguarding. The GP lead engaged with the local safeguarding board and local services, identifying and supporting children and young people at risk of sexual exploitation. Knowledge gained from this engagement had been shared as a learning aid with all staff to support them to identify vulnerable young people who may access services, to ensure they were appropriately supported and safeguarded. Alerts were placed onto the patient's electronic

# Summary of findings

record when safeguarding concerns were raised. Regular liaison took place with the health visitors and the safeguarding lead for the CCG to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided.

**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). This group's needs had been identified and the practice adjusted the services offered to ensure they were accessible, flexible and offered continuity of care. For example, the practice offered early morning appointments Monday to Friday from 8am and late evening appointments once a week up until 8pm.

The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation, sexual health screening and contraceptive services. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

The practice offered online prescription ordering and online appointment services. Telephone consultations were available instead of patients having to attend the practice.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, one of the GP's was the CCG lead for the IRIS programme (a general practice-based domestic violence and abuse (DVA) training support and referral programme). The GP lead was also involved in the training and raising awareness with all practices within the CCG area. Involvement in this programme had resulted in the practice identifying more patients at risk of domestic violence. The CCG had also identified the practice as being a high referrer for patients to gain support from other agencies to improve their health, safety and wellbeing. Reception staff were aware of the practices involvement in this programme and ensured any patients who appeared to be distressed or injured were seen by a GP immediately. The GP lead for the programme ensured all clinicians had access to information leaflets to share with patients during consultations. The practice also supported partner agencies to access the practice to ensure vulnerable patients were seen in a safe environment.

# Summary of findings

The practice ensured that when concerns were identified about a patients wellbeing if they had children this information was referred to the appropriate agencies to maintain their safety.

The practice had a record of carers and used this information to discuss any support needed and to refer carers on to other services if necessary. Staff were aware of local support services to sign post patients to such as Turning Point which assists people with drug and alcohol issues and the Citizen's Advice Bureau.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services. The practice had an in house counselling service that patients who were experiencing anxiety, depression or bereavement were referred to.

# Summary of findings

## What people who use the service say

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection.

We received seven comment cards and spoke with patients. All comments received indicated the staff team were very caring. However three cards indicated dissatisfaction with trying to make an appointment.

Results received from the National GP Patient Survey from July 2015 from a total of 104 responses showed that:

- 92% of patients described their overall experience of this surgery as good compared to the local average of 84% and the national average of 85%.
- 41% found it easy to get through to this practice by phone compared with a local average of 56%.
- 70% of respondents with a preferred GP usually get to see or speak to that GP compared with local average of 55% and national average of 60%.
- 87% said the nurse was good at listening to them compared with local and national averages of 91%.
- 90% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared with a local average of 85%.
- 80% found the receptionists helpful compared with the local average of 86%.

## Outstanding practice

The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, one of the GP's was the CCG lead for the IRIS programme (a general practice-based domestic violence and abuse (DVA) training support and referral programme). The GP lead was also involved in the training and awareness raising with all practices within the CCG area. Involvement in this programme had resulted in the practice identifying more patients at risk of domestic violence. The CCG had also identified the practice as being a high referrer for patients to gain support from other agencies to improve their health, safety and wellbeing. Reception staff were aware of the practices involvement in this programme and ensured any patients who appeared to be distressed or injured were seen by a GP immediately. The GP lead for the programme ensured all clinicians had access to information leaflets to share with patients during consultations. The practice also supported partner agencies to access the practice to ensure vulnerable patients were seen in a safe environment.

# Witton Street Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection was carried out by a CQC Lead Inspector. The team also included a GP specialist advisor and a practice manager specialist advisor.

## Background to Witton Street Surgery

Witton Street Surgery is based in Northwich, Cheshire. The practice treats patients of all ages and provides a range of medical services. The staff team is comprised of five GP partners, three practice nurses, one health care assistant, a practice manager, reception and administrative staff. The practice is a training practice for doctors and at the time of our visit there was also an F2 doctor ( a qualified doctor who is undertaking required post graduate training to support them to work independently and safely as a doctor) working at the practice.

The Practice is open Monday to Friday 8am to 6:30pm and offers extended hours opening on Thursday until 8pm. Patients can book appointments in person, on-line or via the telephone. The practice provides pre-bookable consultations up to two weeks in advance, same day appointments, a triage service to offer advice and signpost patients and home visits to patients who are housebound or too ill to attend the practice. When the practice is closed, patients access NHS East Cheshire Trust for primary medical services.

The practice is part of NHS Vale Royal Clinical Commissioning Group. It is responsible for providing primary care services to approximately 7,158 patients. The practice is situated in an area with less than average levels of deprivation when compared to other practices nationally. Approximately 59% of patients have a long standing health condition, approximately 55% of patients are disability living allowance claimants (per 1000 patients - 2011) and approximately 21% of patients have caring responsibilities. These figures are above average levels when compared to other practices nationally. The practice has a General Medical Services (GMS) contract.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

## How we carried out this inspection

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

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

# Detailed findings

- Is it well-led?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health (including people with dementia)

We carried out an announced inspection of the Practice and in advance of our inspection, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service.

We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 25 June 2015.

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

Good

# Are services safe?

## Our findings

**Safe track record**

There was a system in place for reporting and recording significant events (events where the practitioner can identify an opportunity for making improvements, either because the outcome was substandard or because there was a potential for an adverse outcome). The practice had a significant event monitoring policy and an electronic significant event recording form which was accessible. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years, which allows them to carry on practising). NHS England and the Clinical Commissioning Group had no concerns about the safety track record at the practice.

**Learning and improvement from safety incidents**

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

Clinical and non-clinical staff told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and confident they would be dealt with appropriately and professionally. Staff were also able to describe how changes had been made to the practice as a result of reviewing significant events. For example, as a result of a patient's blood test results not being actioned in a timely manner, the patient experienced a delay in receiving further tests. Following this incident, the protocol and monitoring system for dealing with blood test results was changed to reduce the risk to patients and minimise the potential for a similar incident occurring in the future

**Reliable safety systems and processes including safeguarding**

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers and in hard copy. Staff had access to contact details for both child protection and adult safeguarding teams. A safeguarding audit had been completed to ensure there were appropriate safeguarding systems in place.

Staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role and demonstrated good knowledge and understanding of safeguarding and its application. We looked at a sample of training records that confirmed staff had attended this training.

The practice had dedicated GP leads in safeguarding for both adults and children. They had attended appropriate training to support them in this role, as recommended by their professional registration safeguarding guidance. When the safeguarding lead was unable to attend safeguarding meetings, they completed a report detailing the involvement of the practice in the patient's healthcare and any concerns identified. All staff we spoke to were aware of the leads and who to speak to in the practice if they had a safeguarding concern.

The child safeguarding lead met with the health visitor regularly to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided. The child safeguarding lead was aware of the child sexual exploitation lead in the local multi agency safeguarding hub and received and shared information appropriately to reduce harm to children and young people. Codes and alerts were applied to the electronic case management system to ensure identified risks to children, young people and vulnerable adults were clearly flagged and reviewed.

The practice nurses acted as chaperones (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure) if required and a notice was in the waiting room to advise patients the service was available should they need it. All staff who acted as chaperones had received a disclosure and barring check.

**Medicines management**

Good

# Are services safe?

The practice worked with pharmacy support from the local CCG. The practice undertook regular medicines audits to ensure the practice was prescribing in line with best practice guidelines. For example, one GP had recently carried out an audit of the medicines prescribed to patients with Atrial fibrillation(a heart condition that causes an irregular and often abnormally fast heart rate). This audit reviewed the practices medication prescribing against the current Nation Institute for Health and Care Excellence (NICE) guidelines and resulted in a change in prescribing practices, to ensure patients received optimum treatment for this condition.

The practice had two fridges for the storage of vaccines. One of the practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy (refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the patient) in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Prescription pads were held securely and records were maintained to enable the system to be audited.

Emergency medicines such as adrenalin for anaphylaxis were available. The practice nurse had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

**Cleanliness and infection control**

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Clinical waste disposal contracts and facilities were in place and spillage kits were available. Staff knew what to do in the event of a sharps injury and appropriate guidance was available.

One of the practice nurses was the designated clinical lead for infection control. There was an infection control policy in place and staff had received up to date training. In February 2015, the practice had undertaken a clinical practice improvement tool audit to monitor their compliance with infection control requirements. Actions had been identified and an action plan had been produced to resolve them.

The practice had a record of clinical staff disease screening and their immunisation status to reduce the risk of cross infection for patients.

**Equipment**

All electrical equipment was checked to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example, blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment for them to carry out their role and that equipment was in good working order.

One of the practice nurses carried out regular checks on emergency equipment such as the defibrillator.

In response to patient needs, the practice had recently purchased a bariatric chair to improve the safety and comfort for larger patients.

**Staffing and recruitment**

Staffing levels were reviewed to ensure patients were kept safe and their needs were met. Duty rotas took into account planned absence such as holidays. In the event of unplanned absences, staff from within the service covered non-clinical roles. The practice occasionally used GP locums and appropriate recruitment checks, induction and supervision were carried out for all GP locums.

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

The practice had a recruitment procedure that outlined the checks that were needed prior to the employment of staff. These included obtaining references, checking qualifications and professional registrations and carrying out Disclosure and Barring service (DBS) checks (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). We looked at the recruitment records of four staff (one clinical and three non-clinical) who were amongst the most recent staff to be employed at the service. We found generally all required checks had

been carried out. However, they did not contain evidence of physical and mental fitness. The practice manager told us she would ensure when recruiting new staff health questionnaires would be completed.

The professional registration of clinical staff was checked prior to appointment and we saw an up to date record of on-going professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC).

**Monitoring safety and responding to risk**

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff. There was a fire risk assessment in place. However, the practice had not carried out any recent fire drills but all staff we spoke with knew what to do in the event of fire and fire equipment was checked annually. The practice also had a variety of other risk assessments and audits in place to monitor safety of the premises such as infection control and legionella testing. The practice manager told us that since the completion of recent building work, she was reviewing risk assessments to ensure they were up to date particularly with regard to legionella testing.

**Arrangements to deal with emergencies and major incidents**

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen. There was also a first aid kit and accident book available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do in the event of a major incident.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

Once patients were registered with the practice, the practice nurses carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The nursing staff referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The practice took part in the avoiding unplanned admissions scheme to identify vulnerable patients (identified through clinical risk profiling) and to provide an enhanced service such as providing those patients who had urgent queries with same-day telephone consultations or with follow-up arrangements where required. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed.

The practice was part of a CCG supported scheme to reduce the number of hospital attendance and admissions for patients living in residential and nursing homes. This scheme involved supporting patients and their carers with detailed care plans and the opportunity to meet with the named GP at regular intervals. The scheme also supported GPs to meet with and offer support and education to the nursing home staff to reduce hospital admissions and to support patients to remain at home.

The GPs specialised in clinical areas such as diabetes, minor surgery, child health and sexual health. They were also aware of the specialised needs of the patient population such as patients living in vulnerable circumstances, patients experiencing poor mental health and patients with cancer and those receiving palliative care. The practice nurses managed specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD), childhood immunisations and cervical screening. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

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**

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs and is intended to improve the quality of general practice and reward good practice. The latest QOF points as a percentage of the total available showed the practice to have scored 100% which was higher than the national average of 93.5%.

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice had a system in place for completing clinical audit cycles. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. Examples of clinical audits seen included an audit of patients prescribed the oral contraceptive pill and the health checks carried out prior to medication being prescribed and an audit of patients with atrial fibrillation to ensure the care and treatment provided was in line with current NICE guidelines. Both audits had resulted in changes to how the practice operated to meet patients' health care needs. For example, the initial audit of the prescribing of oral contraceptive led to an increase in blood pressure and body mass index (BMI) health checks being carried out prior to medication being prescribed. The second cycle of this audit showed a further increase in the number of patients receiving these health checks prior to the oral contraceptive being prescribed.

The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of QOF performance. All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as diabetes,

Good

# Are services effective?

## (for example, treatment is effective)

asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients on long term medication, for example for mental health conditions.

The practice website provided patients with detailed information about health condition and the most effective way to deal with them. The website also sign posted patients to other services and support services.

**Effective staffing**

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and information governance.

Staff received annual e-learning that included safeguarding, fire procedures basic life support and information governance awareness. Staff also had access to other e-learning training modules.

The practice nurses attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training.

All GPs were up to date with their yearly continuing professional development requirements and had either been or were in the process of being revalidated. There were annual appraisal systems in place for all other members of staff which included personal development plans.

**Working with colleagues and other services**

The practice worked with other agencies and professionals to support continuity of care for patients. Staff described how the practice provided the out of hours service with information, to support them, such as their details their patients receiving end of life care. There were processes in place to ensure that information received from other agencies, such as A&E or hospital outpatient departments were read and dealt with in a timely manner. There were systems in place to manage blood result information and to respond to any concerns identified. There was also a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients.

Multi-disciplinary team and palliative care meetings were held on a regular basis. Clinical staff met with health visitors, social workers, district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify where further support may be required.

GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences, when they were unable to attend these meetings they provided a report detailing their involvement with the patient. The safeguarding lead met with the health visitor to discuss any needs or concerns about children and young people registered with the practice.

**Information sharing**

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

The practice used summary care records to ensure that important information about patients could be shared between GPs at the practice. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice had several systems in place to ensure good communications between staff. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues.

**Consent to care and treatment**

We spoke with clinical staff about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). A procedure was in place for gaining verbal and written consent from patients, for example, when providing joint injections and minor surgical procedures.

**Health promotion and prevention**

Good

# Are services effective?

## (for example, treatment is effective)

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

The practice monitored how it performed in relation to health promotion. It used the information from QOF and other sources to identify where improvements were needed and to take action. QOF information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions. The practice performed in line with the national average in ensuring women aged 25 – 65 had cervical screening within the last 5 years. The practice offers dietary advice and support through joint working with a dietician who worked at the practice one day per week.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity.

Results from the national GP patient survey (from 105 responses) showed that 90% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 98% said the last GP they saw or spoke to was good at listening to them. Both results were higher than the national and local average when compared to other practices.

We spoke with two members of the Patient Participation Group (PPG) who had worked with the practice for approximately four years. They told us that they had been involved in many projects that had been run at the practice to make patients' wait more efficient. For example, through discussion with the practice they initiated the 'Flu Crew' which consisted of volunteers being available at the practice during flu vaccination clinics to support and direct patients to a single point of access to receive their flu jab from the practice nurses. They told us this system had reduced the time spent by patients having to be booked in by the reception staff. Patients had commented that this system saved both them and the practice staff time.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The waiting room and reception area was small and there was the possibility of being overheard. The practice were aware of this problem and staff we spoke with advised that patients were offered a private area to discuss issues if they so wished.

**Care planning and involvement in decisions about care and treatment**

Results from the national GP patient survey showed that 92% said the last GP they saw or spoke to was good at explaining tests and treatments. This was higher than average when compared with other practices. The survey showed that 82% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care, this was average when compared to other practices. Ninety four percent of respondents said the last nurse they saw or spoke to was good at giving them enough time. This was average when compared to other practices.

**Patient/carer support to cope emotionally with care and treatment**

The practice waiting room displayed information about the support available to patients to help them to cope emotionally with care and treatment. This included information for carers, details about the Citizen's Advice Bureau, advocacy services and mental health support services. Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients for emotional support, for example, following bereavement. A counselling service provided by the practice offered appointments one afternoon per week.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Clinical staff told us how they engaged with Vale Royal CCG, health and social care services to address local needs and service improvements that needed to be prioritised. For example, the initiative to reduce attendance at A&E departments and the number of hospital admissions.

Staff spoken with told us how they responded to the differing needs of patients. We spoke to two members of the PPG who had worked with the practice for over four years. They told us they worked in partnership with the practice and that this had resulted positive changes for patients. For example, patients had raised issues about the length of time they were permitted to park outside the practice and the risk of parking fines. The PPG had raised this issue with the local council who owned the land and their intervention resulted in longer parking times being implemented. Patients spoken with during the inspection told us they appreciated the longer parking times available whilst they were waiting to be treated at the practice.

The practice provided patients through the website a newsletter three times a year to provide updates to issues that affected the practice and patients.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes.

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

Multi-disciplinary team and palliative care meetings where held monthly were patient care was reviewed to ensure patients were receiving the support they required. These meetings included the district nursing team, social workers, community matrons and health visiting team.

The practice was involved in the IRIS programme. The GP lead for this programme was also involved in the training and raising awareness with all practices within the CCG area. Involvement in this programme had resulted in the practice identifying more patients at risk of domestic violence. The CCG had also identified the practice as being a high referrer for patients to gain support from other agencies to improve their health, safety and wellbeing.

**Tackling inequity and promoting equality**

The surgery had access to translation services. The building had appropriate access and facilities for disabled people. The practice website had tools available to patients that allowed them to use a language translator to access the information in a language of the choice and to enlarge the size of the print. The practice had an equal opportunities policy which was available to all staff on the practice's computer system.

**Access to the service**

The practice was open between 8am to 6.30pm Monday to Friday. The practice operated a mixture of routine, same day and emergency appointments. Appointments could be booked up to two weeks ahead and the appointment system allowed GPs flexibility so they could spend longer with patients if they required more time at an appointment. In addition, the practice participated in the extended hours scheme and was open once a week until 8pm to allow patients who could not attend during normal working hours.

Results from the GP national Patient survey showed 41% of respondents found it easy to get through to the practice by phone which was significantly lower than the local average of 56%. The practice manager and senior GP partner told us they were aware of issues with the phone system and monitored this closely. Patients and reception staff told us patients were always given a choice of who they wanted to see and when they wanted to attend.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure detailed how to make a complaint, who to contact and the timescales for the practice to respond. The policy included contact details for NHS England, the Health Service Ombudsman and details of advocacy services to support patients making a complaint. Reference was made to the complaint process in the patient information booklet given to all new patients and on the practice's website. However,

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

the contact details on the practice website were out of date and needed to be up dated to reflect the change in the practice manager. A television screen in the waiting area also provided details of how to make a complaint.

We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint. A complaints log was maintained to enable patterns and trends to be identified. We looked at how three complaints were managed and found they had been appropriately managed and lessons had been learned from them.

# 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 clear aims and objectives which included providing a high-quality, patient-led, primary health care service. This involved patients in all aspects of their health care, providing a timely response to both acute and long-term conditions, ensuring patients saw the most appropriate clinical member of staff and communicating effectively with other health care providers from both primary, secondary and community care settings. The practice had a charter which summarised its aims and objectives and was displayed at the practice and on the website for patients to see.

**Governance arrangements**

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

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

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

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GPs showed improvements had been made to the operation of the service and to patient safety and care as a result of the audits undertaken.

**Leadership, openness and transparency**

There was a leadership structure in place and clear lines of accountability. Staff had specific roles within the practice, and clinical and managerial staff took the lead for different areas, for example, infection control, information governance and clinical audits. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at staff meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed. Staff told us they could raise concerns and felt they were listened to.

We reviewed a number of human resource policies and procedures for example, disciplinary, grievance and capability and the equality and diversity policies and procedures. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow.

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

Results of surveys and complaints were discussed at staff meetings. The reception staff encouraged all patients attending to complete the new Friends and Family Test(The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) as a method of gaining patients feedback.

The practice had an established PPG. We met with members of the PPG who told us they felt they worked in partnership with the practice and effected positive change for the patient population.

**Management lead through learning and improvement**

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. Staff told us the practice was supportive of their learning and

# Are services well-led?

Good

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

development needs and that they felt well supported in their roles. Staff were offered annual appraisals to review performance and identify development needs for the coming year.

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

The practice was a designated training practice for the training and education of student doctors they had robust systems in place to support student doctors. The lead GP told us being part of the education and training of future doctors enabled them as individual clinicians and as a practice to continue to develop and improve the service they provided to patients.