Hope Farm Medical CentreHope Farm Medical Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Hope Farm Medical Centre provides services that include access to GPs and nursing staff for diagnosis and treatment of conditions and illness, minor surgical procedures and ante and post natal health care for mothers and their babies.

Patients of the practice can access extended hours provision from across four local sites early evenings and on a Saturday morning. At all other times out of hours primary care is provided by NHS Western Cheshire.

Patients are predominantly positive about their experiences when they use services provided by Hope Farm Medical Centre. Staff and patients have opportunities to influence changes at the practice.

The practice has clinical and non-clinical lead staff for areas of work. This includes infection control, medication and different aspects of patient care. It is the lead staff members responsibility to ensure their area of work is in line with current best practice guidelines

The practice is registered to provide the following regulated activities, Treatment of Disease, Disorder or Injury, Diagnostic and Screening, Maternity and Midwifery Services, Family Planning and Surgical Procedures.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The practice was safe. Patients were protected from abuse and avoidable harm. The practice had dedicated systems in place to identify and respond to the risk of unsafe practices. Where incidents or accidents occurred or complaints were made the practice responded to improve practice.

Are services effective?
The practice was effective. Patient care and support was delivered in line with best practice guidelines. Patients were referred onto secondary care, as required, to achieve good outcomes. Practice staff were suitably qualified to meet the needs of the patients and available health promotion material supported patients to stay healthy.

Are services caring?
The practice was caring. Patients we spoke with told us they were treated with compassion and respect at all times. Patients were involved directly with their own care and when required with people they cared for. The practice ensured procedures for consent were followed at all times.

Are services responsive to people's needs?
The practice was responsive. Patient feedback and views were gathered on service provision and changes were made as a result. Relevant information was available in different formats if requested.

Are services well-led?
The practice was well led. The practice involved patients and all staff in how it was managed. There were clear governance arrangements that supported delivery of high quality, person centred care. The practice had developed systems that supported learning and promoted an open and fair culture.

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
We found the practice had good services to support the needs of this population group. The practice had agreed protocols for sharing information with other providers. This helped to ensure patient's specific health care needs could be consistently met

People with long-term conditions
We found the practice had good services to support the needs of this population group. The practice had systems in place to support the required monitoring of patients with long term conditions

Mothers, babies, children and young people
We found the practice had good services to support the needs of this population group. Practice staff had attended specific training to meet the needs of mothers and their children

The working-age population and those recently retired
We found the practice had good services to support the needs of this population group. The practice had sourced extended hours services to meet the needs of patients outside of routine office hours

People in vulnerable circumstances who may have poor access to primary care
We found the practice had good services to support the needs of this population group. The practice reviewed the needs of the practice population regularly and sourced services to meet new areas of identified need

People experiencing poor mental health
We found the practice had good services to support the needs of this population group. The practice worked in partnership with local health and care providers to better meet the needs of patients experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed 20 completed CQC comment cards and spoke to 11 patients on the day of the inspection. We spoke to patients from different population groups who had different medical needs and used the practice services differently.

Patient comments were predominantly positive with some negative responses around access to the practice by telephone.

GPs and nurses were praised for listening and giving patients time to both explain their concerns and understand their diagnosis and treatment. We were told recent changes to the telephone system had made it easier to book appointments.

Areas for improvement

Action the service COULD take to improve

Risk assessments to determine whether staff should have regular DBS checks were not undertaken by the practice. The practice checked registrations at the point of recruitment but did not routinely check to ensure staff renewed their registration as required to undertake the role. There was not a physical or mental fitness test or health questionnaire within the recruitment information.

Safeguarding training did not take place at regular intervals; this left staff without the current and most up to date knowledge.

Infection control audits were not reviewed to ascertain actions had been completed in a timely manner. Privacy curtains required cleaning/replacing.

Comprehensive training records were not kept.

Monitoring of the emergency drugs kits and GP bags were not undertaken regularly and consistently. Monitoring did not include detail of clear expiry dates.

Staff did not know the detail of the business continuity plan meaning they were unclear what to do if the practice manager was not on site.

Hope Farm Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The lead inspector was accompanied by a GP, a second CQC inspector and an Expert by Experience. A member of the public employed by CQC to identify and qualify how the practice is meeting the needs of its patients.

Background to Hope Farm Medical Centre

Hope Farm Medical Centre provides primary medical services to 12041 patients living in West Cheshire areas of Ellesmere Port and Neston. The practice is open Monday to Friday 8.00am to 6.30pm.

The practice is a purpose built primary medical service that sees all patients on the ground floor.

The practice clinical staff consists of four partner GPs, two salaried GPs, two Registrars who have recently completed their training, two nurse practitioners, two practice nurses and a health care assistant. Office and support staff include a business and practice manager, secretaries and administrators.

Patients of the practice can access extended hours provision from across four local sites early evenings and on a Saturday morning. At all other times out of hours primary care is provided by NHS Western Cheshire.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before our inspection we reviewed information we hold about the practice and asked other organisations and key stakeholders to share what they knew about the practice. We analysed information received through our intelligence monitoring system and reviewed policies, procedures and

Detailed findings

other information the practice provided before the inspection. The practice had a Patient Participation Group (PPG) and we arranged to speak with two of the members. We carried out an announced inspection on 4th June 2014.

During our inspection we spoke with a range of staff including; GPs, Nurse Practitioners and Practice Nurses, Practice Manager, Health Care Assistant and Reception and Administration staff. We spoke with 11 patients on the day of the inspection and reviewed 20 comment cards available for patients to complete on the day. We observed how patients were being cared for and reviewed documentation and practice records as required.

Are services safe?

Summary of findings

The practice was safe. Patients were protected from abuse and avoidable harm. The practice had dedicated systems in place to identify and respond to the risk of unsafe practices. Where incidents or accidents occurred or complaints were made the practice responded to improve practice.

Our findings

Safe patient care

The practice had named leads for tasks related to patient safety. This included managing medication alerts, significant events, safeguarding and complaints.

Staff understood procedures and protocols for reporting incidents and any concerns. We saw policies that identified how incidents would be managed, which included national and local guidance.

Significant events were discussed in specific practice meetings and each event was allocated a clinical lead. Staff explained when external professionals had been invited to meetings and where GPs from the practice had attended external meetings to inform the internal evaluation of the significant event analysis.

Information on significant events was not easily accessible to the team. The events were recorded and discussed and we saw some evidence to support changes to protocols following a recent significant event.

The complaints procedure had been updated and included details of the NHS customer solution centre. Finalised complaints we saw had followed the practice procedures. An annual report was submitted to the Clinical Commissioning Group (CCG) detailing numbers and types of complaint. The practice manager had completed a report previously which included details of how, when, why and action taken. The report was a good example of how the practice worked to improve patient care. We were told of a recent complaint around access to the building and saw evidence to support the practice investigating and escalating the complaint to reach a satisfactory solution for the patient.

Learning from incidents

The practice had daily meetings to discuss issues and concerns in an open forum as they arose. Weekly meetings took place to discuss and agree actions formally. Practice staff gathered information about learning events and shared them with the team. We saw examples of training days on employment law and programmes for workshops to improve staff and GP knowledge in clinical and non-clinical areas including patient care and information governance

Are services safe?

A secretary coordinated the significant event process and most of the information was held electronically on their system. Significant events and any action taken were not accessible for reference at all times. We could see a comprehensive process of recording and reporting action and events. Information was shared with practice staff via email to ensure everyone saw the information. Information was not stored anywhere centrally so all staff could access it and reflect on the lessons learnt

We saw an incident recorded within the significant events and saw details of how the lead GP was making changes to protocols to ensure the same situation was dealt with differently in the future.

Safeguarding

We saw safeguarding procedures displayed in the staff rooms for both children and vulnerable adults. Procedures included flow charts and phone numbers to raise potential alerts.

Safeguarding was included within the practice induction procedures. This helped ensure all new staff had an immediate awareness of their responsibilities to protect children and vulnerable adults. The practice had arranged safeguarding vulnerable adult's level 2 training from the clinical commissioning group safeguarding lead for July 2014. Staff we spoke with understood their responsibilities in identifying and reporting potential safeguarding alerts. Staff were consistent in their understanding of whistle blowing procedures and would report staff if they felt their behaviour was inappropriate.

The practice did not have a protocol for when they should attend safeguarding strategy meetings. We were told the GP would always provide a report if they had raised the alert and would attend if practical to do so.

We were told patient notes identified if patients were involved in or under a safeguarding investigation.

Monitoring safety and responding to risk

A schedule of meetings was available within the practice. The daily lunchtime meetings identified emerging risks on a day to day basis. Risks to individuals were assessed and home visits were agreed as required.

The practice had procedures for dealing with incidents that posed a risk to both staff and patients. This included spillage kits and procedures for dealing with bodily fluids such as vomit and blood. We were told of the emergency call system used to get support within emergency situations.

The practice had appropriate numbers of clinical and non-clinical staff. We were told short term sickness was covered with ease. Part time staff would work extra time if it was required to support each other and meet the needs of the practice.

Medicines management

We saw from staff induction records and available guidance information staff had received an introduction to prescription medication. Staff we spoke with were confident of the procedures for ordering prescriptions.

The practice had a prescriber mentor who all staff could go to for specific advice. The practice were about to start quarterly meetings to discuss any issues with prescribing and medication. The senior partner attended a prescribing group chaired by the CCG. Medication alerts were discussed at the group and actions to be taken bought back to the practice to implement. Alerts were distributed to relevant staff at the practice by the named medication alerts assistant.

Medication reviews were completed by the GPs. We spoke with the GP about how they ensured medication was regularly reviewed. We were told different ways were used dependent on the patient involved. This could include withholding certain medications or organising a telephone consultation to ensure the review was undertaken at the earliest point.

The practice had held uncollected prescriptions for a period of time. It was unclear how often these were reviewed as some of them dated back eight weeks. We saw some prescriptions had been duplicated because a review of the prescriptions had not been undertaken. There could be concern if someone was not collecting a prescription and their medication was required to keep them safe. The practice protocols for dealing with uncollected prescriptions stated a review should take place every four weeks.

The practice did not hold any controlled drugs on site. Medication kept in the refrigerator was stock controlled with the oldest item being at the front of the fridge to be used first.

Are services safe?

We saw medication reviews were undertaken following alerts and saw changes in prescribing specific medications took place as a consequence. However it was not always clear when changes had not taken place and the reason why not. We discussed two alerts with the GP and were told specific details were being discussed within the local prescribing group. The GPs had not written on patient notes why even after a review of medications, changes had not been made to the medication around which an alert had been raised. We were told consideration would be given as to how records were kept when medication had not been changed following a review and that the risk verses benefits would be recorded in a timelier manner.

Two emergency drugs kits were available for practice staff. Whilst expiry dates for medication were found to be in date, there was not a system in place to record expiry dates. The Health Care Assistant (HCA) monitored the GP bags and emergency drugs periodically to ensure they had the correct stock within them and none had expired but this would only be known at the time of the check. This left the risk of not knowing a drug had expired until it was needed in an emergency. We saw one drug within the one GP bag we checked had an item out of date. We were told the HCA had not received any specific training to record the expiry dates.

Cleanliness and infection control

The practice had an infection control clinical lead that undertook an annual audit and chaired quarterly practice infection control meetings. A non-clinical lead was responsible for the domestic staff and checked cleaning schedules were completed in their required frequency. The last infection control audit had been completed in January 2014. The action plan had not been reviewed to determine what actions remained outstanding. Staff we spoke with were not clear on when privacy curtains were last washed. Curtains we saw were visibly marked.

Equipment used for routine cleaning was colour coded and stored appropriately. When we spoke with staff they understood the different systems for different areas of the practice. We saw cleaning schedules were signed to confirm cleaning had taken place, we were also told the non-clinical lead would do daily spot checks in different areas of the practice to ensure records were accurate.

Staff we spoke with were confident in managing clinical waste. We saw sharps bins and foot operated clinical waste bins were in use in the consulting and treatment rooms. We saw waste was correctly segregated and appropriate waste receptacles were available as required. This included sharps bins and different coloured waste bags. We saw transfer notes that confirmed waste was collected and disposed of weekly.

We saw supplies of Personal Protective Equipment (PPE) and we saw disposable gloves and other necessary PPE was available in all treatment rooms.

Staff had not completed formal infection control training which made it difficult to ascertain the practice expectation on staff competency.

Staffing and recruitment

We saw from recent recruitment procedures the practice had gathered identification and references from applicants. Staff had been issued with contracts and had undertaken an induction. Risk assessments to determine whether staff should have regular Disclosure and Barring Service (DBS) checks were not undertaken by the practice. The practice checked registrations at the point of recruitment but did not routinely check to ensure staff renewed their registrations as required to undertake the role. There was not a physical and mental fitness test or health questionnaire within the recruitment information.

We saw evidence of the staff induction and one new member of staff described it as 'the best induction they had received'. The staff handbook included details of policies and procedures for human resources. Staff signed the handbook to state they had read and understood the procedures.

Dealing with Emergencies

The practice had procedures for dealing with emergencies and staff had received various training to support these. Staff said they had attended their required Cardio Pulmonary Resuscitation (CPR) and emergency first aid training and we saw certificates to support this.

The practice had a business continuity plan. The plan included risk management plans in the event of a number of circumstances that included loss of power and the event of the practice building becoming uninhabitable. Staff were unsure of the procedures to following the event of an emergency but were aware of whom they would report to if had any concerns in this area.

Are services safe?

The practice had completed a fire evacuation drill in April 2014. A fire risk assessment had been completed but was not seen on the day of the inspection. We saw fire extinguishers had been last checked in February 2014. Staff said they had completed annual fire drill training.

Equipment

We looked at the available equipment within the practice for use in an emergency. We saw the oxygen cylinder and defibrillator were checked regularly and records were kept in a log book of what was checked and whether anything had been replaced.

The three fridges used by the practice were checked daily and the temperature recorded and monitored.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Patient care and support was delivered in line with best practice guidelines. Patients were referred onto secondary care, as required, to achieve good outcomes. Practice staff were suitably qualified to meet the needs of the patients and available health promotion material supported patients to stay healthy.

Our findings

Promoting best practice

The practice had GP's with different special interests and skills. All clinicians had access to changes in legislation and good practice guidelines. The practice received updates through the practice manager and also directly from the clinical commissioning group (CCG). Where guidance was received that impacted on treatment, the lead GP searched the patient list and informed their GP if a change in therapy was required. The lead would also update the practice protocol to reflect the change in guidelines.

The hard copy National Institute for Health and Care Excellence (NICE) guidelines for infection control were out of date. We discussed with the GP how protocols were reviewed and updated. Each GP had a folder on the internal electronic system within which they kept all the protocols and guidance for their lead area. We discussed the difficulties in accessing a specific protocol in the current system and the benefits of a central resource accessible to all staff.

We spoke with GPs and nurses about specific care and treatment of people with complex health needs. We were told of the care planning the practice staff undertook in different settings. This included patients in care homes and hospices and patients who visited the practice with chronic diseases or learning difficulties. GPs and other staff would do searches on patient lists to identify patients in at risk groups following alerts or who were due for reviews or tests to manage conditions.

We spoke with the lead GP about consent and capacity. We were told the GP would ask to see power of attorney information from family members if it was in place and may suggest an application for power of attorney may be considered. We discussed informed consent and best interest decisions under the Mental Capacity Act. The GP had undertaken capacity assessments to support best interest decisions made regarding patient's treatment.

Consent procedures took into account capacity and included the input of carers and parents as appropriate. The GP was clear they would have known patients over a period of time and would know them well enough to make

Are services effective?

(for example, treatment is effective)

best interest decisions. We were told if they were in any doubt they would get further support from social services. We were told patient records held a code to identify when a patient was being cared for or who may lack capacity.

Management, monitoring and improving outcomes for people

We spoke with staff that had the lead role in different areas. Each staff member both clinical and non-clinical understood their roles. New staff to the practice were encouraged to develop an area of interest to support the team. This approach helped ensure the practice consistently developed and improved provision as required.

Lead staff would develop quality assurance information and undertake clinical audit to manage improvement. We spoke to two GPs, one registrar and one practice nurse in more detail about their lead area.

Clinical audits were undertaken in response to alerts, appraisals or revalidation requirements or day to day quality assurance purposes. We reviewed a clinical audit for chlamydia screening. We saw an initial screening exercise was undertaken that identified numbers and current practice. Discussions were held and changes to practice agreed over a three month audit window. Results were then collected and analysed and presented to the practice. A further follow up audit to evaluate if the changes in practice had resulted in better take up by patients of the screening opportunity, was to be undertaken.

Each lead we spoke with consistently reviewed practice and made improvements as required. Improvements could be made following incidents, alerts, training, shared learning or changes to guidelines or legislation.

Each practice completed an annual self-assessment against a national set of targets for quality healthcare provision. The targets were developed from good practice guidelines from experts in different fields of practice. We looked at the available self-assessment indicators, (Quality and Outcome Framework (QOF)). The practice reviewed their self-assessment throughout the year. We were told of changes to ensure every effort was made to ensure the QOF target was met. This included a specialist clinician who undertook a smoking cessation clinic once a week to help the practice improve on this standard.

Staffing

Four GP partners were supported by a range of clinical and non-clinical staff. The majority of the staff at the practice had been employed for several years.

Once in post staff received a comprehensive induction and staff told us they could attend additional training if they requested it. Staff were encouraged and supported to develop and we were told there were 12 protected learning half days each year. We saw records of attendance at mandatory training and staff each told us of specific training they had attended for their personal development.

Staff had received formal annual appraisals and regular meetings took place for peer support. We were told the practice was a learning and supportive environment to work in. The clinicians were praised for being caring about their staff and one staff member told us they were simply asked regularly if they were ok and that was positive.

There were clear lines of management and clinical supervision, Staff we spoke with said they were suitably supported to undertake their role and keep up the requirements of their continued professional development (CPD).

Records of induction and training could be better managed to enable an overview of who had received what and when. Administrative and secretarial staff had received training but the records and evaluation of training were minimal.

We saw records of managing poor performance. Records included additional supervision and training. When situations escalated and disciplinary action had to be taken the practice sought advice from employment law experts.

We saw good induction procedures to support staff at the start of employment and saw how the practice managed capability issues when staff required further support. The GPs and all staff received an annual appraisal to set individual objectives and identify training needs.

Working with other services

A quarterly meeting took place with the district nurses to discuss palliative care support for patients during the later stages of their life. The practice shared information about advance directives and end of life wishes with out of hours and the extended hours provision. This ensured that

Are services effective?

(for example, treatment is effective)

services were aware of patients wishes at all times. One of the GP partners was a lead for palliative care and was on call for the local hospice one evening a week. Good practice was shared with the other GPs at Hope Farm.

We were told the practice nurses attended nursing homes five afternoons a week. A GP supported the nurses as required. The nurses worked with staff at the homes to deliver a holistic treatment service to the patients.

We saw minutes and were told of a number of multi-disciplinary forums the practice staff attended. The practice managed a number of enhanced services (services to support specific groups or health conditions) and attended meetings to support their management.

Patients said they had confidence in the treatment provided by the practice and were confident if the practice could not meet their needs they would be referred to somewhere where they could. The practice used the Single Point of Access (SPA) service for support managing patient care and treatment. Support was provided wherever possible to avoid hospital admission and included support at home or a temporary residential bed until patients were able to manage with less support.

The practice worked within usual arrangements for transition between services and would follow up relevant information, if required, to ensure the patient could be supported effectively. The GP checked the practice clinical system daily to ascertain if any patients had visited the out of hours service. Where appropriate the GP updated the patient's records and changed any prescribed medication if required.

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient information with other services allowed external services to work with patients quicker than if the information was not available.

Health, promotion and prevention

The practice was proactive in identifying carers and had a dedicated notice board. Carers were asked to identify themselves and additional assessment was offered if required.

When new patients joined the practice either as a temporary or permanent patient a health check was completed. The check identified any immediate health care or social care needs and included details of habits that could be detrimental to patients health including smoking and drinking. The practice clinician referred patients to the dietician as required.

The practice had many leaflets and posters to view within the main reception area. Information was available about general and specific health promotion. Secondary and voluntary service information was available that included support services for specific conditions and peer support groups for patients recently bereaved.

The practice had access to the translation services line if someone who could not speak English came to the practice. Information could be requested in different languages, formats and prints if people requested it.

Are services caring?

Summary of findings

The practice was caring. Patients we spoke with told us they were treated with compassion and respect at all times. Patients were involved directly with their own care and when required with people they cared for. The practice ensured procedures for consent were followed at all times.

Our findings

Respect, dignity, compassion and empathy

All of the 11 patients we spoke with said they were treated well by all of the clinical and reception staff at the practice. We received two negative comments within the 20 comment cards we collected about patients feeling patronised. Patients felt supported and well cared for and we were given examples where patients had influenced changes in their treatment or medication.

Information we received from patients told of staff who had the time to listen and support them. We saw consultation rooms were private and patients told us they were offered a chaperone during private or sensitive examinations. We spoke to three staff that had been trained to act as a chaperone to patients.

The practice had a Patient Participation Group (PPG) and patients were asked to join and become involved with the operating of the practice. We spoke with two members of the group who told us how the PPG worked with the practice. Members felt the group was effective at making changes and consulted with patients for their opinion. We were told how the practice telephone system had changed to relay a voice message to callers that informed them of where they were in a queue rather than to receive an engaged dialling tone.

Patients said they felt they could talk in confidence with staff members at the reception desk but if they wished, could be taken into a more private room. Patients told us they had time to talk with the GP and nurses within appointments. One patient said, “All the Doctors are excellent and really listen to me, and I would not cope without them.”

The patient information leaflet held details of patients’ rights and responsibilities. The leaflet identified how patients should expect to be treated respectfully and explained details of the chaperone, confidentiality and privacy policies adhered to by the practice.

We saw information within the waiting room in leaflets and on posters that offered support to patients and families at time of bereavement. Information included practical advice and on-going support for grief.

Are services caring?

Involvement in decisions and consent

Patients said they were involved with their care and treatment. One person told us, "I was prescribed one set of medication but I didn't think it agreed with me and it was changed straight away." Patients understood the chaperone policy and had been offered the service. We were also told patients understood they could have family members and carers present during appointments if they wished.

The practice had a consent policy which included different forms of consent. The policy identified where 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. We spoke with one patient who gave us assurances they were involved with the decision making process of a family member who lacked capacity.

Consent procedures included the Gillick assessment undertaken on young people to ascertain if they understand diagnosis, treatment, risks and issues and consequences. When the assessment determines someone under 16 has the capacity to understand these things they may consent to their own care and treatment.

Staff we spoke with had a good understanding of the different types of consent.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive. Patient feedback and views were gathered on service provision and changes were made as a result. Relevant information was available in different formats if requested.

Our findings

Responding to and meeting people's needs

The practice was well designed for people using a wheelchair to have easy access to the different treatment rooms. Hallways and doorways were wide enough to accommodate a wheel chair. Hand rails were positioned along corridors to support people with mobility if required and a disabled toilet was available.

The practice undertook a number of enhanced services to meet local needs. Different staff members took lead roles and attended relevant meetings with the local healthcare community.

We spoke with patients who had been referred appropriately when their needs could not be met by the practice. We spoke with one patient who got an immediate appointment and transfer to the local hospital following chest pains. The practice worked with specialist services and completed interim assessments and tests for the local hospitals as required. Test results could be accessed via a dedicated test results line.

The practice had undertaken an audit of referrals to secondary care to determine the suitability of services offered by the practice. The analysis of the results supported how the practice deployed available staff to enable them to meet the primary care needs of patients within the practice.

The practice held a number of clinics for different patient groups and conditions. Check-ups and reviews were maintained through patient contacts that included letters, telephone consultations and follow up appointments.

The practice staff told us they had arrangements for working with patients through transition from hospital to home or home to residential care. This included formalised protocols for sharing of information that included medication and support requirements.

Access to the service

The practice had recently made some changes to the appointment system to allow for more appointments to be pre-booked. On line bookings could be made up to a month in advance to allow patients more choice

and flexibility in appointments. Telephone appointments could be made daily. Each day four appointments were

Are services responsive to people's needs?

(for example, to feedback?)

available for each GP. Once these were filled with on the day appointments, patients who required to see a GP in an emergency could wait and see one at the end of a scheduled session.

The practice leaflet identified all available arrangements for appointments which included extended hours appointments at different local practices and out of hours appointments with West Cheshire out of hours services.

We were told by patients, if they needed an appointment on the same day they would get it. Staff said patients were triaged in the mornings and given appointments according to their need. Appointments were left free every day to be filled in the event of an emergency. On the day of the inspection we saw patients booking different appointments with reception staff.

The practice had two disabled parking spots and a lowered door release button was available at the entrance to the practice building.

Concerns and complaints

The practice had a complaints procedure and kept a record of responses and actions taken as a consequence. Patients we spoke with had not seen the complaints procedure but were confident they would know how to make a complaint if needed.

Staff we spoke with said they would tell patients to write a letter to the practice manager if they had a complaint. This may not be an easy approach for patients with difficulty writing.

The practice manager monitored complaints and completed an annual submission to the CCG identifying the type and number of complaints received at the practice.

The practice had changed the system and time length for pre booked appointments to one month following a number of complaints from patients. This showed the practice was willing to make adjustments to how services were delivered following a review of complaints received.

Are services well-led?

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

Summary of findings

The practice was well led. The practice involved patients and all staff in how it was managed. There were clear governance arrangements that supported delivery of high quality, person centred care. The practice had developed systems that supported learning and promoted an open and fair culture.

Our findings

Leadership and culture

Staff said they enjoyed their work and were clear about lines of management and direct responsibilities. There were clinical and non-clinical structures for staff supervision, appraisal and day to day support. Staff felt supported by their managers and part of the bigger practice team.

The practice held regular business meetings to discuss issues about clinical and non-clinical concerns in an open forum. Staff told us the patient was at the heart of what they did and there were principles of good practice that involved the patient in the delivery of their own care.

The practice had four GP partners and two salaried doctors. Clear objectives were set around establishing the new lead GP and structures for the development and delivery of new objectives were taking shape. This included the development of meetings to set and review the practice aims and objectives

Governance arrangements

The practice had a clear governance structure where each team member was aware of and accountable for different responsibilities. Staff knew who the leads were, if they wanted to know the latest guidance or protocols in specific areas.

Systems to monitor and improve quality and improvement

We saw how each person monitored and audited their responsible practice lead area to ensure they remained accountable for current practice. A central storage place for monitoring, protocols and audits would support peer review and help determine actions were taken in a timely manner.

We were told how quality monitoring was undertaken monthly on all services and clinics provided by the practice. This information discussed at practice meetings was used to inform the annual quality self-assessment (QOF) and helped the practice continually improve and raise standards.

Patient experience and involvement

We spoke with 11 patients and collected 20 CQC comment cards completed by patients for the CQC staff to review. We found from comment cards and the patients we spoke

Are services well-led?

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

with, that generally patients were very happy with the practice. All patients spoke highly of the clinical staff and felt involved with their treatment. The last patient questionnaire completed in January 2014 showed patients were less complimentary about getting through to the practice by telephone. The practice told us they had made recent improvements to the phone system as a consequence. The next patient consultation would evaluate if the changes had impacted on the patient experience.

The practice had a Patient Participation Group (PPG) which met bi-monthly. We spoke with two of the PPG members who both said they felt involved with the recent improvements to the telephone system. The minutes of the meetings were held on the practice website and accessible to all patients.

The Patient Participation Group (PPG) vice chair attended a forum for PPG lead members. The meeting hosted by NHS England shared information for dissemination with the practice management. Items discussed included the PPG role and wider NHS patient involvement initiatives.

Patients were asked for feedback regularly. The practice manager used information from a variety of sources that included comments and complaints to inform changes in practice.

Staff engagement and involvement

We saw a schedule of meetings for staff to attend on the staff notice board. We saw meeting minutes that showed staff were actively involved in meetings and could influence both the agenda and actions agreed. Staff said they felt involved with how the practice was managed. We spoke with both nurses and GPs who told us how they updated protocols based on their lead area. We saw learning events where the updates were shared with the staff team.

Learning and improvement

Personnel records showed us new staff had completed a comprehensive induction. Training records identified when staff had attended medical emergency and safeguarding training. Staff told us they completed annual training on fire evacuation and individuals attended training and meetings for which they were the lead. For example the prescribing lead attended training and quarterly meetings to inform best practice in that area.

Regular meetings and forums for shared learning took place. All staff had protected learning time to complete modules for their Continued Professional development (CPD) and staff attended learning events hosted by the Clinical Commissioning Group (CCG)

Identification and management of risk

The practice was to develop both individual and team objectives to review management systems and performance. Current working arrangements included reviews managed by different area leads. The practice was to develop a strategic plan based on current best practice and identify and develop a risk register for regular review and evaluation. This was due to be started by the new registered manager.

Policies and procedures were reviewed annually by an external company. Updates and amendments were sent to the practice and the practice manager delivered them to the team within the bi-weekly business meetings. We saw minutes where changes to protocols were discussed and staff we spoke with were aware of updates.

The current structure managed patient risk through daily meetings of all GP's and nurses. Home visits were planned and general learning was shared from team leads.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

We found the practice had good services to support the needs of this population group. The practice had agreed protocols for sharing information with other providers. This helped to ensure patient's specific health care needs could be consistently met.

Our findings

Safe
The practice had taken steps to incorporate learning from the Mental Capacity Act. Safeguarding vulnerable adults training was set up to be delivered shortly. Staff we spoke with were aware of how to identify and report potential abuse.

Caring
The practice had systems in place to support older people as they moved between home and different support settings. Information was shared with all providers including any information on directives for end of life. Practical information was available on how to cope with bereavement.

We saw information for elderly patients on befriending services available in the local community.

Effective
The practice held quarterly meetings with palliative care teams and district nurses to co-ordinate support for people at the end of their life.

We saw information was available on services to support people living with dementia included local support groups and day centres.

Responsive
The practice had an advance directive and palliative care template they shared with OOH and extended hours services to ensure all services had the information they needed to support people when the practice was closed.

Well-led
The practice lead for palliative care worked on call at a local hospice one evening a week. The lead had access to up to date learning around palliative care. The information was shared with the practice to support learning in this area.

Staff could access training on dementia through the local Clinical Commissioning Group (CCG).

Older people

The practice undertook an enhanced service for residential and nursing care. Two nurse practitioners and one GP were allocated to support local elderly people in these settings.

Staff attended quarterly meetings where leads were available from areas such as gerontology (study of old age and conditions associated with old age), hospice services and the Alzheimer's society.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

We found the practice had good services to support the needs of this population group. The practice had systems in place to support the required monitoring of patients with long term conditions.

Our findings

Safe

Long term conditions were monitored by practice nurses. Clinics were generally managed by nurse practitioners but medication reviews were always undertaken by the GP. Medication review dates were printed onto the repeat prescription sheet for patients to book appointments. Where patients were reluctant to attend for reviews GPs would not stop medication if it posed a risk to patient safety. The review would take place at the patient's next appointment.

Caring

Patients we spoke with were involved with their treatment. We were told systems were in place to ensure patients always had access to medication they needed in an emergency.

Effective

The practice had a number of information leaflets with details of living with long term conditions. Information from national charitable organisations included Diabetes UK and the Alzheimer's society.

Responsive

Most long term conditions required on-going health monitoring. The practice held a diary that included details of every patients review dates. Reviews would include various tests relevant to the condition. Each patient was sent a review letter around the time of their birthday requesting they make an appointment with the clinic. Patients would get reminder letters to encourage patients to make the appointments.

Well-led

We spoke with patients who had influenced changes within the practice. One patient told us they could now book a review up to a month in advance where previously it had been more difficult.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

We found the practice had good services to support the needs of this population group. Practice staff had attended specific training to meet the needs of mothers and their children.

Our findings

Safe

We saw safeguarding children posters within the staff room. All staff had received training in this area. Staff we spoke with were confident they could identify and report any concerns.

A significant event analysis had been completed following a patient request for a child with a rash to be seen by the GP. The patient had been advised to attend A&E. The analysis led to changes in procedures and protocols to provide an emergency appointment to children with unknown rashes.

Caring

We saw consent procedures that included parental consent for childhood immunisations. Mothers we spoke with said they were treated with respect and were given the time they needed to explain what was wrong with their child.

Effective

Staff could access training in areas that interested them. We spoke to one practice nurse who had recently attended training in contraception.

We saw a clinical audit had been undertaken to determine the reasons for the low take up of chlamydia screening. Changes to how the requests were made had been implemented and a follow up audit was due to ascertain if more patients had been screened.

Responsive

Ante and post natal clinics were held at the practice. Clinics were held for all stages of childhood development. Mothers received information for attendance at clinics and childhood immunisations

Patients we spoke with who had small children said they could get to see the GP on the same day in the event of an emergency.

Mothers, babies, children and young people

Well-led

Medication reviews recorded on repeat prescriptions had included details of appointments due for potentially sensitive and personal check-ups. Following concerns raised by some patients this information was removed and patients received this information by letter.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

We found the practice had good services to support the needs of this population group. The practice had sourced extended hours services to meet the needs of patients outside of routine office hours.

Our findings

Safe

Protocols and systems were in place at the practice to protect all patients from potential harm. Procedures and equipment were in place to deal with unforeseen emergencies.

Caring

One patient told us how helpful the practice was when sharing information and advice on holiday vaccinations. Appointments were arranged at convenient times to ensure the patient was protected in their chosen holiday destination.

Effective

We saw information on general health promotion that included combating stress and smoking cessation.

Responsive

We were told an appointment could be booked in advance of when it was needed or if required outside of working hours options were available. The practice had access to both extended hours and out of hours provision. This meant that patients could access appointments outside of working hours without attendance at A&E.

Well-led

Changes to the appointment system allowed working patients to book routine appointments in advance with a practitioner of their choice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We found the practice had good services to support the needs of this population group. The practice reviewed the needs of the practice population regularly and sourced services to meet new areas of identified need.

Our findings

Safe

The practice staff took steps to support patients healthcare needs in residential care. When patients were discharged from hospital, practice staff, ensured residential staff had the information they needed to support the patient in the community.

Caring

We spoke with one patient and their carer. We were told that when they were discussing the health care needs of their family member they never felt rushed and felt involved with any decisions. We were told, “We just have a good chat about things”

Effective

We saw information about services to support people in vulnerable circumstances.

We spoke to the practice about working with people with learning disabilities we were told a care plan was completed and health care plans were developed and shared with other agencies involved with supporting patients.

Responsive

The practice had taken steps to support people using a wheelchair. We discussed with the GP how appointment times were managed. We were told appointments were not booked for any longer length of time and they may run late if there were delays with physical access to the practice and treatments rooms. We were assured the reception staff would inform other patients if there was going to be a delay to their appointment.

Well-led

The practice reviewed its services year on year. When an area of clinical need was identified and additional support was required the practice would apply for that support. If

People in vulnerable circumstances who may have poor access to primary care

the practice could identify local support networks it would ensure they were utilised. The practice would always register temporary patients but was aware the town had a local practice that worked more specifically with homeless people and would refer on as required.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

We found the practice had good services to support the needs of this population group. The practice worked in partnership with local health and care providers to better meet the needs of patients experiencing poor mental health.

Our findings

Safe
The practice included other health and care providers as necessary to implement learning. The mental health team had been invited to attend a significant event review. This helped the practice ensure they were informed to make any changes to provision if required.

Caring
The practice worked within integrated care pathways which had been developed from local strategic frameworks. This included inclusion of mental health services with young people assessed as being at risk of self-harm.

Effective
The practice worked with other professionals to support patients with poor mental health. A local GP forum discussed issues that included commissioning and access to services.

Responsive
Through the local forum for mental health enhanced services the practice shared practical examples and discussed ways to improve.

Well-led
The local forum group discussed urgent care and how improvements could be made in line with national directives. Directives included those with poor mental health not to be turned away from services. The practice had a plan in place to better utilise the single point of access system to ensure patients received the appropriate treatment at the appropriate time.