

York Road Group Practice

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at York Road Group Practice on 6th October 2015.

Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were aware of procedures for safeguarding patients from risk of abuse.
- There were appropriate systems in place to reduce risks to patient safety, for example, infection control procedures and the management of medication. However, the records of some environmental safety checks and the recruitment records needed improvement.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.

- Patients were overall 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.
- Services were planned and delivered to take into account the needs of different patient groups.
- Feedback from patients indicated they considered improvements were needed to availability of appointments, length of time waiting to be seen and access to the practice by phone. The practice had made changes to the service to improve access and planned on making further changes.
- The practice sought patient views about improvements that could be made to the service and acted on patient feedback. Information about how to complain was available.
- There were systems in place to monitor and improve quality and identify risk.

There were areas of practice where the provider needs to make improvements:

The provider should:

Summary of findings

Introduce a formal system to review significant events to ensure the identified action has been undertaken and that it has been effective.

Ensure that a system is in place to check the on-going registration of GPs with the General Medical Council and the National Performers List.

Ensure that a record of all checks undertaken in relation to staff recruitment are held at the practice.

Ensure that appropriate checks of the water systems are undertaken and that the emergency lighting is regularly serviced and records are held to demonstrate this.

Ensure that actions taken following the investigation of complaints are fully documented to demonstrate that appropriate measures have been taken.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff were aware of procedures for reporting significant events and safeguarding patients from risk of abuse. There were appropriate systems in place to protect patients from the risks associated with medication and infection control. Improvements were needed to the records of staff recruitment and some environmental safety checks.

Good



Are services effective?

The practice is rated good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had received training appropriate to their roles.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated good for providing responsive services. Services were planned and delivered to take into account the needs of different patient groups. Patients' feedback indicated improvements were needed to waiting times, access to the practice and getting an appointment. The practice were aware of this and had introduced changes and planned further changes to address this. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. Complaints were managed appropriately although, the practice should ensure that actions taken following the investigation of complaints are fully documented to demonstrate that appropriate measures have been taken.

Good



Are services well-led?

The practice is rated good for being well-led. It had a clear vision and strategy. There were systems in place to monitor and improve

Good



Summary of findings

quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice was forward thinking and was part of local initiatives to improve outcomes for patients in the area.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care and to offer services such as vaccinations for flu and shingles. All patients over 75 had a named GP who was responsible for co-ordinating their care. The practice had identified patients at highest risk, for example, due to multiple medical problems, frailty/falls and recent hospital admissions and a care plan had been developed to support them. The practice worked with other agencies and health providers to provide support and access specialist help when needed. For example, the practice was able to contact a Community Frailty Team led by a Consultant Geriatrician for advice and rapid assessment of patients at high risk. A monthly multi-disciplinary meeting was held to discuss patients with complex needs and how best to support them. The practice was one of four local practices that had worked together with the Clinical Commissioning Group (CCG) and secured funding to develop initiatives to improve patient care. One of the first major projects being undertaken was setting up a joint Early Visiting Service whereby a GP would assess older patients with acute problems during the morning and mobilise any necessary resources such as community support services to optimise patient care. If a hospital admission was required then research had shown that an early assessment could result in a reduced length of stay. Services for carers were publicised and a record was kept of carers to ensure they had access to appropriate services.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions. Clinical staff were skilled in dedicated areas and their on-going education meant that they were able to ensure best practice was being maintained. Patients who were housebound were visited at home by the nurse practitioner for annual reviews of long term conditions. The nurse

Good



Summary of findings

practitioner provided a service for initiating injectable treatments for patients with type 2 diabetes which had reduced secondary care referrals. A GP took the clinical lead for diabetes and had developed diabetes care at the practice which had resulted in improvements to the service provided to patients. The practice had multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs.

Families, children and young people

The practice is rated as good for the care of families, children and young people. Child health surveillance and immunisation clinics were provided. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. There was a policy of same day appointments for all children. Contraceptive and sexual health services were provided. The staff we spoke with had appropriate knowledge about child protection and they had access to policies and procedures for safeguarding children. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. The safeguarding lead GP liaised with the health visiting service to discuss any concerns about children and how they could be best supported.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered pre-bookable appointments, book on the day appointments and telephone consultations. Patients could book appointments in person, on-line or via the telephone and repeat prescriptions could be ordered on-line which provided flexibility to working patients and those in full time education. An extended hour's service was provided by West Cheshire CCG. This service was publicised at the practice and on the practice website. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance. For example, if a patient had a learning disability to enable appropriate support to be provided. Staff we spoke with had appropriate knowledge about safeguarding vulnerable adults and they had access to the practice's policy and procedures and had received training in this. The practice referred

Good



Summary of findings

patients to a Well-being Co-ordinator who provided advice and support to patients around issues such as housing problems and benefit issues and was able to sign post patients to other sources of support.

People experiencing poor mental health (including people with dementia)

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). GPs worked with specialist services to review care and to ensure patients received the support they needed. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health, including dementia, an annual health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information for patients in the waiting areas to inform them of services available for patients with poor mental health. For example, services for patients who may experience depression. Clinical and non-clinical staff had undertaken training in dementia to ensure all were able to appropriately support patients.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 (data collected July-September 2014 and January-March 2015) showed the practice was generally performing in line with local and national averages in relation to care and treatment and patient involvement in decision making. Some responses were slightly above local and national averages. There were 118 responses to the survey which represents 1.0% of the practice population.

- 92.7% said the GP was good at listening to them compared to the CCG average of 92.1% and national average of 88.6%.
- 98.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.9% and national average of 95.3%.
- 92.7% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.6% and national average of 85.1%.
- 98.9% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97.2%.
- 95.2% said the nurse gave them enough time compared to the CCG average of 93.3% and national average of 91.9%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91.8% and national average of 90.4%.
- 85.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85.5% and national average of 81.5%.
- 82.2% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85.9% and national average of 84.9%.

The national GP patient survey also showed that patient's satisfaction with opening hours was comparable to local and national averages:

- 76.2% of patients were satisfied with the practice's opening hours compared to the CCG average of 74.7% and national average of 75.7%.

However, the numbers of patients rating their experience of making an appointment as good and access to the practice by phone was much lower than local and national averages.

- 55.6% patients described their experience of making an appointment as good compared to the CCG average of 72.9% and national average of 73.8%.
- 36.2% patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 74.4%.

We received 30 comment cards and spoke to five patients. Overall, the responses indicated staff were caring and helpful and patients were provided with the care and treatment needed. Nine comment cards raised issues about access, commenting that there could be a long wait to see a GP when attending for an appointment, not being able to get through on the telephone and not being able to get an appointment when it was convenient. We spoke to five patients, three raised similar issues concerning access.

A GP partner and the practice manager told us that the practice had been operating with one less GP partner over the last twelve months and they had been unable to secure continuous locum GPs to cover this shortfall. The practice were actively advertising for a salaried GP. The practice had also had one nurse less over this period although this position has now been filled. In order to improve access to services the practice had made changes to its operation, including, altering how staff were deployed to provide further staff to answer telephones, employing two apprentices to assist with telephone answering, actively encouraging patients to use the self-check in and reducing time spent managing prescriptions by using the electronic prescribing system. The practice had a high number of patients who did not attend for appointments and steps had been taken to address this. Further changes to improve patient access were also planned such as reducing booking ahead for appointments from 4 weeks to 2 weeks, reviewing the triage system and training one of the practice nurses in the treatment of minor illnesses. The practice was also considering not accepting any new patients on a temporary basis.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

Introduce a formal system to review significant events to ensure the identified action has been undertaken and that it has been effective.

Ensure that a system is in place to check the on-going registration of GPs with the General Medical Council and the National Performers List.

Ensure that a record of all checks undertaken in relation to staff recruitment are held at the practice.

Ensure that appropriate checks of the water systems are undertaken and that the emergency lighting is regularly serviced and records are held to demonstrate this.

Ensure that actions taken following the investigation of complaints are fully documented to demonstrate that appropriate measures have been taken.

York Road Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to York Road Group Practice

York Road Group Practice is responsible for providing primary care services to approximately 11669 patients. The practice is based in a more deprived area when compared to other practices nationally.

The staff team includes five partner GPs, one nurse clinician, four practice nurses, two health care assistants, a practice manager and reception and administrative staff. The practice is a training practice and at the time of our visit had one GP registrar working for them as part of their training and development in general practice.

The practice is open from 08:00 to 18:30 Monday to Friday. West Cheshire CCG provides an extended hours GP service 18:30 to 21:30 Monday to Friday and 10:00 to 12:00 on Saturdays.

Patients requiring a GP outside of these hours are advised to contact the Cheshire West Out of Hours Co-operative which is staffed by GPs from practices in Ellesmere Port. This service is based at Ellesmere Port Hospital.

The practice has a General Medical Services (GMS) contract. The practice offers a range of enhanced services including minor surgery, flu and shingles vaccinations and learning disability health checks.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Detailed findings

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

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 6th October 2015. We reviewed all areas of the practice including the administrative areas.

We sought views from patients face-to-face during the inspection, we looked at survey results and reviewed CQC comment cards completed by patients. We spoke with a representative from the Patient Participation Group (PPG). We spoke to clinical and non-clinical staff. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We explored how the GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting, recording and investigating significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to staff via computer. The practice carried out an analysis of significant events and this also formed part of the GPs' individual revalidation process. The practice held staff meetings at which significant events were discussed in order to cascade any learning points. We looked at a sample of significant event records and spoke to staff and found that action had been taken to improve safety in the practice where necessary. However, we noted that a formal system was not in place to review significant events to ensure the identified action had been undertaken and that it had been effective.

Overview of safety systems and processes

- Arrangements were in place to safeguard adults and children from abuse. Safeguarding policies and procedures were accessible to all staff and outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The practice had systems in place to monitor and respond to requests for attendance/reports at safeguarding meetings. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. Some clinical staff were in need of refresher training which had been arranged. Any concerns about the welfare of younger children were discussed with the health visiting service for the area. Alerts were placed on patient records to identify if there were any safety concerns.
- We were informed that all staff who acted as chaperones had received a disclosure and barring check (DBS) (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the records of these checks were held by the staff members and were not available to be reviewed. Chaperones had received training for this role. Some reception staff had been trained as chaperones but were not undertaking these duties until a DBS check had been returned. We

noted that information advising patients that a chaperone was available if required was not displayed in the waiting areas. The practice manager informed us that this had been addressed following the inspection.

- There were procedures in place for monitoring and managing risks to patient and staff safety. A fire risk assessment was in place and routine servicing of the fire safety systems were undertaken. The practice manager informed us that the emergency lighting was routinely serviced, however evidence to indicate the date of the last check was not available. The portable electrical equipment had last been tested in February 2012. A date for re-testing had been arranged. Records showed that clinical equipment was checked to ensure it was working properly.
- We looked at a sample of treatment and consultation rooms and the waiting areas. All areas seen were clean. Appropriate standards of cleanliness and hygiene were followed. For example, cleaning schedules were in place, there was access to protective clothing and equipment and there was a system for the safe disposal of waste. We noted that some of the decoration was showing signs of wear and tear and the seats in the waiting area were covered with material which may not make them easy to keep clean. There was an infection control protocol in place for staff to refer to. Some clinical staff had received up to date training and guidance around infection control procedures and some were due to attend refresher training. Guidance around infection control procedures had been provided to non-clinical staff. There was a lead for infection control who liaised with the local infection prevention teams to keep up to date with best practice. An infection control audit had been carried out in April 2015 by the local infection prevention team which demonstrated good systems were in place to prevent infection. An action plan had been put in place to address the shortfalls identified. A risk assessment for the management of legionella indicated the premises were low risk but recommended that the water temperature should be tested monthly and recorded. This was not being recorded.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular

Are services safe?

medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely managed. Vaccines were securely stored, were in date and we saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of vaccines.

- Recruitment checks were carried out and the two files we reviewed showed that in general appropriate recruitment checks had been undertaken prior to employment. For example, references were obtained, physical and mental fitness had been assessed, qualifications and registration with the appropriate professional body had been checked and interviews carried out. Clinical staff and one other member of staff who acted as a chaperone told us they had either had a criminal records bureau (CRB) or a disclosure and barring service (DBS) check, however, individual staff held this information and we were not shown records to confirm this. A system for undertaking regular checks of the registration of GPs on the Performers List and

General Medical Council (GMC) was not in place. Some of the GPs had received CRB checks several years ago. We noted that a policy for renewing these checks was not available.

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 had received basic life support training, however, several clinical staff needed to attend refresher training and this had been organised for November 2015. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We noted that a warning sign indicating the storage of oxygen was not displayed. Following the inspection we were informed that appropriate signage had been ordered. There were emergency medicines available which were all in date and held securely.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We noted however, that some clinical staff had not received recent training in the Mental Capacity Act or Deprivation of Liberty Safeguards. This training was being planned to address this. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Consent forms for surgical procedures were used and scanned in to the medical records.

Protecting and improving patient health

The practice offered national screening programmes, vaccination programmes, children's immunisations and long term condition reviews. Health promotion information was available in the reception area and on the website. The practice had links with smoking cessation and alcohol services and staff told us these services were pro-actively recommended to patients. The practice was committed to young people and teenage health promotion initiatives. Guidance around sexual health was provided and confidential chlamydia testing for patients aged 16-24 was offered. Screening and assessments for depression were undertaken and physical checks for people suffering from mental health conditions.

Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns. New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment with the practice nurse.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify

where improvements were needed and to take action. This is a system intended to improve the quality of general practice and reward good practice. Quality and Outcomes Framework (QOF) information for the period of April 2013 to March 2014 showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. There were systems in place to ensure relevant information was shared with other services in a timely way, for example when people were referred to other services. Staff worked with other health and social care services to meet patients' needs. The practice had multi-disciplinary meetings to discuss the needs of palliative care patients and patients who were at risk of unplanned hospital admissions.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF) system and used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Patients who had long term conditions were continuously followed up throughout the year to ensure they attended health reviews. Current results were 98.7% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013-2014 showed:

- Performance for diabetes assessment and care was higher or slightly higher than the national averages.
- Performance for mental health assessment and care was higher than the national averages.
- Performance for cervical screening of eligible women (aged 25-64) in the preceding five years was similar to the national average.
- The percentage of patients with hypertension having a blood pressure test in the last 9 months was similar to the national average.

Are services effective?

(for example, treatment is effective)

- The percentage of patients with atrial fibrillation currently treated with anticoagulation drug therapy or an antiplatelet therapy was 100% when compared to the national average of 98.32%.
- The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who were currently treated with an appropriate bone-sparing agent was 100% when compared to the national average of 81.27%.

The practice had strategies in place to manage and improve outcomes for patients. For example, the nurse practitioner provided a service for initiating injectable treatments for patients with type 2 diabetes which we were told had reduced secondary care referrals.

We saw that audits of clinical practice were undertaken. Examples of audits included audits of the prescribing of medication to ensure appropriate practices were being adhered to. We also saw a cancer audit which showed that referrals were completed appropriately and led to an analysis of cancer diagnosis in patients with upper gastro-intestinal symptoms. The GPs told us clinical audits were often linked to medicines management information, safety alerts, clinical interest or as a result of Quality and Outcomes Framework (QOF) performance. All the clinicians participated in clinical audits. We discussed audits with GPs who told us they met to discuss outcomes of audits so they could learn from them and improve their practice. We noted that a record of these information sharing meetings was not consistently maintained.

The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included managing long term conditions, medication prescribing, diabetes, safeguarding, child surveillance and promoting the health care needs of patients with a learning disability and those with poor mental health.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed that:

- The practice had an induction programme for newly appointed staff. New members of staff spoken with confirmed they had received an induction. We looked at the records of induction for non-clinical members of staff and saw that this covered such topics as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through appraisals, meetings and reviews of practice development needs. Staff told us they felt well supported and had access to appropriate training to meet these learning needs and to cover the scope of their work. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months. We noted that there was a robust system in place for the support of GP registrars.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules, in-house training and training provided by external agencies. Some staff needed training updates in basic life support and safeguarding which was being addressed. The records of staff training did not fully reflect the training staff told us they had undertaken. We noted that a complete record of all staff training needed and undertaken was not available which would assist in monitoring and planning for the training needs of staff.

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. Curtains were provided in consulting 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.

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

We received 30 comment cards and spoke to five patients. This indicated that overall patients considered their privacy and dignity were promoted and they were treated with care and compassion.

Data from the National GP Patient Survey July 2015 showed that patients responses about whether they were treated with respect and in a compassionate manner by clinical staff were generally in line with local and national averages. Some responses were slightly above average when compared to local and national averages:

- 92.7% said the GP was good at listening to them compared to the CCG average of 92.1% and national average of 88.6%.
- 86.2% said the GP gave them enough time compared to the CCG average of 90% and national average of 86.8%.
- 98.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.9% and national average of 95.3%.
- 92.7% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.6% and national average of 85.1%.

- 98.9% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97.2%.
- 91.3% said the nurse was good at listening to them compared to the CCG average of 92.1% and national average of 91%.
- 95.2% said the nurse gave them enough time compared to the CCG average of 93.3% and national average of 91.9%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91.8% and national average of 90.4%.
- 83.4% of patients found the reception staff helpful compared to the CCG average of 86.9% and the national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt health issues were discussed with them, they received the care and treatment they needed and they felt listened to.

Data from the National GP Patient Survey July 2015 information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were generally in line with local and national averages. For example:

- 87.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88.8% and national average of 86.3%.
- 85.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85.5% and national average of 81.5%.
- 92.8% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90.3% and national average of 89.7%.
- 82.2% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85.9% and national average of 84.9%.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to improve outcomes for patients in the area. For example, the practice offered a range of enhanced services such as dementia assessments and avoiding unplanned admissions to hospital. The practice was one of four local practices that had worked together with the CCG and secured funding to develop initiatives to improve patient care. One of the first major projects being undertaken was setting up a joint Early Visiting Service whereby a GP would assess older patients with acute problems during the morning and mobilise any necessary resources such as community support services to optimise patient care. If a hospital admission was required then research had shown that an early assessment could result in a reduced length of stay.

The practice had multi-disciplinary meetings to discuss the needs of palliative care patients, patients with complex needs and patients who were at risk of unplanned hospital admissions.

The practice had a Patient Participation Group (PPG) with 24 members who met quarterly with practice staff (some members communicated via email), carried out patient surveys and made suggestions for improvements. We met with a representative from the PPG. They told us they felt they were listened to and that their opinions mattered. They said and records showed that improvements had been made to the practice as a result of their involvement. For example, greater information had been provided to patients about the health and social care services available in the local community and better use had been made of information technology to improve services provided to patients. The practice was setting up a virtual PPG to encourage a broader age range of patients to participate.

Services were planned and delivered to take into account the needs of different patient groups. For example;

- There were longer appointments available for patients who needed them, such as patients with a learning disability, poor mental health or who had long term conditions.

- Urgent access appointments were available for patients following a triage telephone consultation with a GP. Priority was given to children and those with serious medical conditions.
- Home visits were made to patients who were housebound or too ill to attend the practice.
- There were disabled facilities, hearing loop and translation services available. Most staff had undertaken deaf awareness training.
- Staff spoken with indicated they had received training around equality and diversity.
- The practice referred patients to a Well-being Co-ordinator who provided advice and support to patients on a number of issues, including, debt management, housing, social isolation.
- The practice had a newsletter to keep patients up to date with any changes and services available.
- Reception staff had received training in dementia awareness to assist in identifying patients who may need extra support.

Access to the service

The practice was open from 08:00 to 18:30 Monday to Friday. West Cheshire CCG provided an extended hours GP service 18:30 to 21:30 Monday to Friday and 10:00 to 12:00 on Saturdays. Appointments could be booked up to four weeks in advance. Patients requiring a same day appointment had a telephone consultation with a GP prior to an appointment being offered. The practice nurse prescriber offered minor illness appointments. Telephone consultations were also offered. Patients could book appointments in person, on-line or via the telephone. Repeat prescriptions could be ordered on-line or by attending the practice.

Results from the national GP patient survey from July 2015 (data collected from January-March 2015 and July-September 2014) showed that patient's satisfaction with opening hours was comparable to local and national averages:

- 76.2% of patients were satisfied with the practice's opening hours compared to the CCG average of 74.7% and national average of 75.7%.

However, the numbers of patients rating their experience of making an appointment as good and access to the practice by phone was much lower than local and national averages.

Are services responsive to people's needs?

(for example, to feedback?)

- 55.6% patients described their experience of making an appointment as good compared to the CCG average of 72.9% and national average of 73.8%.
- 36.2% patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 74.4%.

We received 30 comment cards, nine raised issues about access, commenting that there could be a long wait to see a GP when attending for an appointment, they were not able to get through on the telephone and not being able to get an appointment when it was convenient. We spoke to five patients, three raised similar issues concerning access. One patient raised the issue of delayed access to repeat prescriptions.

A GP partner and practice manager told us that the practice had been operating with one less GP partner over the last twelve months and had been unable to successfully secure locum GPs to cover this shortfall. The practice were actively advertising for a salaried GP. The practice had also had one nurse less over this period and had been unable to secure full cover for this position. This position has now been filled. In order to improve access the practice had made changes to its operation, including, altering how staff were deployed to provide further staff to answer telephones, employing two apprentices to assist with telephone answering, actively encouraged patients to use the self-check in and reducing time spent managing prescriptions by using the electronic prescribing system. The practice had a high number of patients who did not attend for appointments and steps had been taken to address this. Further changes to improve patient access were also planned such as reducing booking ahead for

appointments from 4 weeks to 2 weeks, reviewing the triage system and training one of the practice nurses in the treatment of minor illnesses. The practice were also considering not accepting any new patients on a temporary basis.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about how to make a complaint was available for patients to refer to in the waiting room and on the practice website. The complaints' policy outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log for written complaints. We reviewed three complaints received within the last 12 months. They had been investigated and records generally demonstrated the actions taken to improve practice where appropriate. One complaint about clinical practice indicated that as a result of the investigation the practice would not use the services of a locum GP in the future. Records did not show that his information had been clearly communicated to the locum agency responsible for the employment of the GP. Following our visit the practice provided a letter sent to the locum agency regarding its decision.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to ensure all members of the team were dedicated to providing patients with a continuous quality of service to achieve the best medical care which met with patient requirements. This was displayed in the patient information leaflet, waiting area and on the website and staff we spoke with knew and understood the values of the practice.

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. The registered manager and the practice manager met to look at the overall operation of the service.

There was a leadership structure in place and clear lines of accountability. We spoke with clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager, registered manager or a GP partner. Staff told us they felt the practice was well managed.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. We looked at a sample of policies and procedures and found that the policies and procedures required were available. However, we noted some were dated 2013 and were due for a review. We also noted that the whistle blowing policy did not contain contact details of organisations that staff could refer concerns to.

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

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

The practice had systems in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events. We noted that a formal system was not in place to review significant events to ensure the identified action had been undertaken and that it had been effective.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. Patients could leave comments and suggestions about the service via the website or via a comments box in the waiting room. The practice also sought patient feedback by utilising the Friends and Family test. The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

The practice team was forward thinking and was part of local initiatives to improve outcomes for patients in the area. For example, the practice was one of four local practices that were working together to set up an early visiting service to older patients to avoid hospital admissions or reduce the length of hospital stay. The practice was also working with the Clinical Commissioning Group to improve joint working with the ambulance service to improve patient care and outcomes. The practice was

Are services well-led?

Good 

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

planning to pilot a patient mentorship scheme where patients with long term conditions would receive training to enable them to support other patients with similar conditions.