# Upton Rocks Surgery

## Quality Report

Widnes RU Car Park
Heath Road
Widnes
Cheshire
WA8 7NU
Tel: 01515117530
Website: www.ssphealth.com

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

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

**This practice is rated as Good overall.**

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Upton Rocks Surgery on 29 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a clear focus on continuous learning and improvement at all levels of the organisation.

We saw an area of outstanding practice:

- The practice had identified members of staff as champions for patients with a learning disability, dementia and cancer and for patients who had been bereaved or who acted as carers. The provider told us these patients were proactively contacted by the

# Summary of findings

champions so they knew about the support available, were also signposted to the most appropriate services, received timely intervention and the care they needed.

**Professor Steve Field** CBE FRCP FFPH FRCGPChief Inspector of General Practice

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

# Summary of findings

## The six population groups and what we found

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

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

# Upton Rocks Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector**.** The team included a second inspector and a GP specialist adviser.

## Background to Upton Rocks Surgery

Upton Rocks Surgery is operated by SSP Heath GPMS Ltd. Following a change to the details of the provider this service was re-registered in February 2016. It is located at Heath Road Widnes, Cheshire, WA8 7NU in the car park of Widnes Rugby Union car park. There is also a branch practice which is situated in Hale Village approximately three miles from the main practice. The website address is www.ssphealth.com

The practice provides a range of primary medical services including examinations, investigations and treatments and a number of clinics such as clinics for long term conditions like diabetes, asthma and hypertension, travel and children's immunisations clinics.

The practice is responsible for providing primary care services to approximately 3678 patients. The practice is based in an area with higher levels of economic deprivation when compared to other practices nationally.

The staff team includes one male and two female GPs who have independent contracts with the provider. The practice also has a locum GP (the provider has recruited a team of GPs referred to as bank GPs who can provide short term cover at their practices) one day per week. To promote continuity of care this is usually the same clinician. One female practice nurse and one female health care assistant. The non-clinical team includes a regional manager, a practice manager and reception and administrative staff.

Upton Rocks Surgery is open from 8am to 7.30pm on Monday and from 8am to 6.30pm Tuesday to Friday. The branch surgery is open Wednesday 1pm-2.30pm and Friday 12.30pm-2pm. Patients also have access to a local walk-in centre which is open every day. Patients requiring a GP outside of these hours are advised to contact the GP out of hours service, by calling 111.

The main practice delivers services from a porta cabin building. The surgery has been operating from the porta cabin for approximately 17 years. A ramp is available at the front of the building to assist with access. A large car park is available for patients and staff. The provider told us that they are working with the Clinical Commissioning Group (CCG) and Patient Participation Group (PPG) to ensure the practice remains viable for the future. This includes consultation about the relocation of the main site and the sustainability of the branch practice.

The practice has a Primary Medical Service (PMS) contract. The practice offers a range of enhanced services including, learning disability health checks, childhood immunisations and vaccines and seasonal influenza and pneumococcal vaccines.

Good

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as good for providing safe services.**

**Safety systems and processes**

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had safety policies which were communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. from abuse. Policies were accessible to staff and outlined who to go to for further guidance. The provider had a corporate level safeguarding lead who staff were able to contact if they had any concerns, or there were issues with a patient that they were unsure about. Alerts were placed on the records of vulnerable adults and children. Meetings were held to discuss patients where concerns had been identified.
- The practice worked with other agencies to support patients and protect them from neglect and abuse.
- The practice carried out (DBS
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. We noted that the administrative staff could be provided with further guidance on the presenting symptoms of sepsis. Following the inspection the practice manager confirmed that this guidance had been provided.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

**Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies, for example, referrals to enable them to deliver safe care and treatment.

**Safe and appropriate use of medicines**

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had a system for the safe use of prescription stationery.
- Clinical staff told us they prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice involved patients in regular reviews of their medicines.
- The practice worked with the medicines manager from the CCG and had an in-house pharmaceutical advisor for safe prescribing.

**Track record on safety**

Good

# Are services safe?

The practice had systems in place to promote safety.

- The practice monitored and reviewed activity such as significant events, patient safety alerts, referral and prescribing practices. This helped it to understand risks and gave a basis on which to make safety improvements.
- There were risk assessments in relation to safety issues.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following a significant event where a patient received two sets of the same vaccination a check list was introduced to ensure questions were asked to prevent a similar occurrence. The checklist had been shared with the other practices operated by the provider to prevent a similar incident arising.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as good for providing effective services overall and across all population groups.**

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. Our discussions with clinicians and review of guidance they referred to indicated they assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

- Our discussions with clinicians and review of patient records showed patients' needs were appropriately assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff told us that they advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- As part of an enhanced service a named GP visited a local nursing home weekly undertaking reviews, attending to acute illness and updating care plans. Whilst undertaking these visits the GP also saw patients who were registered with the practice and not part of this enhanced service.
- The practice participated in an over 75 years project, the aim being to enhance the care of these patients, reduce avoidable admissions and connect patients to social and health services. The practice had identified patients at risk of unplanned hospital admission and a care plan had been developed to support them.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. The provider told us that by March 2018 all eligible patients would have received this health check which would assist in reducing the number of unplanned hospital admissions and improving the health and wellbeing of older patients.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- There was a clear pathway for referring patients who needed a possible hospital admission due to a deterioration in their long term condition.
- Rescue packs (medication to manage flare ups) were provided to patients with chronic obstructive pulmonary disease (COPD) to reduce the risk of hospital admission.
- The practice had a member of staff who acted as the champion for cancer and who contacted all newly diagnosed patients to ensure they had follow up appointments, medication and support.

Families, children and young people:

- Maternity, family planning, child health surveillance and immunisation services were provided. Weekly and ad-hoc immunisation clinics and eight week baby checks were provided to allow flexibility.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- Family planning and sexual health services were provided.
- The staff told us how they worked collaboratively with community midwifery and other services to support families, children and young people.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 78%, which was comparable with the 80% coverage target for the national screening programme and above the CCG (72%) and national (72%) screening rates. The practice promoted the importance of this screening, offered opportunistic screening and sent reminder letters.

Good

# Are services effective?

## (for example, treatment is effective)

- The practice encouraged eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice offered a health check every five years to patients aged 40-74. This included a cardio vascular risk assessment to patients who do not have any existing chronic diseases. The practice told us they had completed 49% of these assessments for eligible patients and were inviting outstanding patients to attend. Our discussions with staff indicated there was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice held registers of patients living in vulnerable circumstances such as patients with a learning disability or dementia. The practice had devised an important person register to monitor any at risk patients.
- The practice told us how they worked with other agencies to offer health care to vulnerable patients. For example, they worked with a local agency to engage and offer care to patients who had been victims of human trafficking.
- Services for carers were publicised and a record was kept of carers to ensure they had access to appropriate support. A member of staff acted as a carer's champion and they were working to identify carers and promote the support available to them.
  The practice referred patients to local health and social care services for support, such as drug and alcohol services and benefit advice.

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

The most recent published Quality Outcome Framework (QOF) results indicate:-

- 79% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the CCG (83%) and national (84%) averages.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the CCG (93%) and national (90%) averages.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the practice achieved 100% for giving verbal advice about alcohol consumption to patients with poor mental health which was above the local (CCG) score of 94% and national score of 91%; and the percentage of patients experiencing poor mental health who had received verbal advice about smoking cessation was 98%; which was comparable with the local CCG 96% and national 95% scores.

**Monitoring care and treatment**

The practice undertook quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. For example, we saw that audits of clinical practice were undertaken. Examples of audits included audits of medication to ensure appropriate prescribing and to ensure changes were made if necessary. Audits of cancer referrals, cytology and the management of high risk medications. The audits showed the changes that had been made to practice where this was appropriate.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 97%. The overall exception reporting rate was 11% compared with the CCG average of 11% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) We found that overall results were comparable to the CCG and national averages, however results in relation to patients with poor mental health having care plans and blood pressure readings for patients with diabetes were higher than local and national averages, for example:-

Good

# Are services effective?

## (for example, treatment is effective)

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (practice 93%; CCG 82%; national 78%).

Staff worked with other health and social care services to meet patients' needs. The practice had multi-disciplinary meetings to discuss the needs of patients with complex and palliative care needs.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice manager told us that the provider ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Newsletters were distributed on a quarterly basis to all clinicians providing clinical updates, for example, MHRA drug safety updates and Public Health England updates to guidance.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff told us how they ensured patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

**Helping patients to live healthier lives**

Staff were proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff told us how they encouraged and supported patients to be involved in monitoring and managing their health.
- The practice told us how they promoted early screening when risk factors for developing a long-term condition or serious illness had been identified.
- Staff told us how they discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- Flu clinics were provided to patients eligible for this vaccination.
- Travel advice and immunisations were provided.
- The practice referred patients to services that could support them with their health such as alcohol and drug misuse services.

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Good

# Are services effective?

## (for example, treatment is effective)

- Clinicians supported patients to make decisions. Where appropriate, they assessed and told us they recorded a patient's mental capacity to make a decision.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. Information promoting equality and diversity was displayed.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 14 Care Quality Commission comment cards. Overall they were positive about the service experienced. We spoke with nine patients and overall they described the practice as caring and said the staff were respectful and compassionate.
- The practice together with the Patient Participation Group (PPG) had held coffee mornings to raise money for Alzheimer's and cancer charities. These events had involved representatives from the charities being available to provide information to patients. The practice also supported the Text Santa charity and had annual Christmas Jumper days with the proceeds being donated to Save the Children or a charity chosen by the PPG.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and seventy two surveys were sent out and 121 were returned. This represented about 3% of the practice population. The results showed that patients responses were in line with local and national averages:

- 87% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 85% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 83% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 91% of patients who responded said they found the receptionists at the practice helpful; CCG - 82%; national average - 87%.

The practice reviewed national GP patient survey results and discussed them with the Patient Participation Group (PPG) to establish how the practice was performing and where any improvements could be made.

The practice carried out its own annual patient survey. We saw that 44 responses had been received to the survey carried out in 2017. The responses indicated that patients responded positively to questions about having confidence and trust in clinical and non-clinical staff, being treated with dignity and respect and indicated patients were overall happy with their experiences of the service.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices

in the reception areas in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 103 patients as carers (2.8% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. A dedicated noticeboard was on display in the waiting area with information for carers and contact details of organisations that provided carers with support.
- A member of staff had responsibility for co-ordinating bereavement advice and support. Staff told us that if families had experienced bereavement, they were contacted by the most appropriate member of staff to offer support and guidance on local services available and they were also sent a sympathy card.

Results from the national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were in line with local and national averages:

- 79% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 80% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 79% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of treating patients with dignity and respect.
- The practice protected patient confidentiality by providing staff training in information governance and confidentiality and having procedures to support this training.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as good for providing responsive services.**

**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests and booking appointments were provided. The practice had 295 patients over the age of 70 and had developed services suitable to meet the needs of this patient population as detailed below. The practice opened until 7.30pm on Mondays as it had identified that some patients needed later appointment times. The practice was not renumerated for this.
- The practice improved services where possible in response to patient needs. For example, changes to the way prescriptions were managed had been made following patient feedback.
- The practice made reasonable adjustments when patients found it hard to access services. For example, home visits to patients unable to attend the surgery.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Referrals were made to local services to support patients. For example, referrals were made to the Social Care in Practice (SCIP) team who were able to see patients at the practice and signpost them to social agencies for support needs that could not be met by GP services such as packages of social care and dealing with social isolation and housing issues.

Older people:

- The practice participated in the enhanced service for reducing unplanned hospital admissions.They told us they had identified patients at risk of an unplanned admission and developed care plans to support them. Following on from this the practice have continued to monitor these patients and identify further patients at risk by using a fragility assessment tool, offering an annual review looking at patients physical, mental health and social needs and any support needed.
- There was a dedicated phone line for patients and outside agencies, such as the ambulance service, for patients on the avoiding unplanned hospital admission register. This helped to avoid possible delay in getting through to the practice.
- The practice had implemented full health reviews for patients aged 65 years and over including pulse checks for early identification of any heart condition including atrial fibrillation.
- Staff told us they worked with local pharmacies to ensure older patients found prescription ordering and collection accessible and convenient.
- The provider told us they held regular coffee mornings to encourage patients to come together and reduce social isolation.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. The practice offered consultations of up to 60 minutes for patients with multiple conditions. Staff told us that this approach improved the likelihood of patients having their long term conditions reviewed,provided flexibility to patients and enabled patients to ask questions and not feel rushed.
- The practice nurse carried out long term condition reviews in patients homes if they were unable to attend the practice. The practice told us that they coordinated patient reviews with flu and pneumococcal immunisations.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice was awarded a 'Baby Welcome' accreditation from the Department for Health for

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

making the practice accessible to and welcoming for nursing mothers and parents with young children. The practice supported breast feeding and made patients aware there was a room available for this.

- A letter of congratulation was sent to the parents of new babies. The provider had won an award for producing an Early Years Fact Sheet which was sent to new parents providing health and support information such as vaccination schedules, breast feeding and signposting to support services. The provider told us that providing this information to parents has contributed to ensuring uptake of cytology screening and immunisations. This fact sheet was being used at other services operated by the provider.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. For example, there were late evening appointments available with GPs, the practice nurse and health care assistant. An in-house phlebotomy service was offered. Stable patients were offered anti-coagulation monitoring at the practice and other patients were sign posted to a local clinic to avoid unnecessary travel and to ease the process of regular blood screening.
- Appointments and repeat prescriptions could be managed on-line, there was on-line access to medical summaries and telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The provider had developed a "text to cancel" service which allowed patients to cancel unwanted appointments, improve access and reduce missed appointments. This had been awarded a GP Enterprise Award from the Royal College of General Practitioners (RCGP) in 2015.

People whose circumstances make them vulnerable:

- The practice held registers of patients living in vulnerable circumstances including patients with a learning disability. The practice had a learning disability champion who monitored this register and ensured these patients attended any arranged appointments and were invited for an annual health review. Home visits were available for patients with a learning disability to reduce anxiety.
- The practice referred patients to appropriate services such as domestic abuse services, counselling services, military veterans service and to the community wellbeing officer. The community wellbeing officer attended the practice every week and supported patients to develop the skills and knowledge to improve their own wellbeing and to become resilient in the face of difficulties.
- The practice liaised with the local foodbank and held food vouchers for patients who needed them. The practice also housed a food drop off point which was accessed by local people in need.

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

- 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 had a dementia champion who monitored the dementia register to ensure these patients received the service they required.
- Reception staff were aware of patients that needed additional support and contacted patients on the dementia register on the day of their appointment to remind them to ensure they received the care they needed.
- The practice told us how they worked with external mental health professionals in the case management of people experiencing poor mental health, including those with dementia. There were clear pathways to refer patients who may need urgent support.
- The practice referred patients to appropriate services such as memory clinics, psychiatry, counselling and alcohol and drug misuse services. Patients were able to self-refer for counselling. Patients were also signposted to relevant services such as Age UK and the Alzheimer's Society.

**Timely access to the service**

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Fourteen comment cards were returned and we spoke to nine patients. Overall they reported good access to the service. Two of the patients who returned comment cards and two of the nine patients spoken with said there was a lack of continuity of GPs. The provider told us that since a GP had left in February 2017 they had experienced difficulty recruiting a long term GP and that a number of bank GPs (employed by the provider) had worked at the service. A third GP had now been appointed and all sessions apart from two were covered by three long term GPs. The remaining two sessions were covered by the same GPs where possible. The provider told us that they anticipated these changes would improve patient perception of GP continuity.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was either comparable to or above local and national averages. Three hundred and seventy two surveys were sent out and 121 were returned. This represented about 3.2% of the practice population.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 75% of patients who responded said they could get through easily to the practice by phone; CCG – 56%; national average - 71%.
- 83% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 81%; national average - 84%.
- 87% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 75% of patients who responded described their experience of making an appointment as good; CCG - 65%; national average - 73%.
- 81% of patients who responded said they don't normally have to wait too long to be seen; CCG - 53%; national average - 58%.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available in the patient information leaflet and in the waiting area. Staff told us how they treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Twelve complaints were received since April 2016. We reviewed three complaints and found that they were responded to in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, changes in the way prescriptions were managed had been introduced.

# Are services well-led?

Good

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

## Our findings

**We rated the practice as good for providing a well-led service.**

**Leadership capacity and capability**

Leaders had the capacity and skills to deliver good-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider had a realistic strategy and they told us they had supporting business plans to achieve priorities.
- Staff told us they were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

**Culture**

The practice had a culture of good-quality sustainable care.

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients. The practice had identified members of staff as champions for patients with a learning disability, dementia and cancer and for patients who had been bereaved or who acted as carers. The provider told us that these patients were proactively contacted by the champions so that these patients knew they were supported, signposted to the most appropriate services and received timely intervention and the care they needed.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- The practice promoted equality and diversity. Staff had received equality and diversity training.
- Staff told us there were positive relationships between staff and teams.
- The provider told us how they motivated and recognised staff achievement. The nursing and administrative staff were incentivised to achieve an extra weeks holiday a year by meeting key performance indicators for health outcomes and patient satisfaction. The provider also hosted an annual awards event where staff could be nominated by their peers for recognition and awards and awards which were given for outstanding contributions to patient care.

**Governance arrangements**

There were clear responsibilities, roles and systems of accountability to support good governance and management.

# Are services well-led?

Good

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

- Structures, processes and systems to support good governance and management were clearly set out and understood.
- The practice was part of SSP Health and received clinical and administrative support from the wider organisation. This provided benefits to the staff working at Upton Rocks Surgery such as reducing clinical isolation. For example, the organisation had a medical director who was available for clinical support and advice and there was a safeguarding lead for the organisation who could be contacted for guidance and support. Other benefits of being part of a wider organisation included access to training provided to all staff employed by the provider such as educational sessions for GPs, safeguarding and chronic disease updates. Staffing matters were also dealt with by a centralised team leaving the practice manager to concentrate on the direct operation of the service and the administrative team had guidance and leadership from a senior head office team.
- There were clear systems to enable staff to report any issues and concerns.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The practice leaders told us and a sample of records reviewed confirmed that they had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

**Managing risks, issues and performance**

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance.
- The practice had a business continuity plan which covered major incidents such as power failure or building damage and included emergency contact numbers for staff. This was discussed at staff meetings to familiarise staff with the plan.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were policies, procedures and staff training for data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**The practice encouraged and valued feedback from patients, staff and external partners.**

- The views and concerns of patients', staff and external partners' were encouraged and acted on to shape services and culture.For example, the practice gathered feedback from staff through staff meetings and informal discussion. The practice had a system for the management of complaints. The practice 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. Results from October

# Are services well-led?

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to December 2017 showed there had been 383 responses completed and the majority of the respondents were either extremely likely or likely to recommend the practice (October 88%, November 87% and December 90%).

- There was an active patient participation group (PPG). We met with representatives of the PPG who told us they were kept informed about any changes at the practice and worked with the practice to find solutions to issues raised by patients. They said they felt they were listened to and changes had been made to the practice as a consequence. For example, the PPG had requested that patients living closer to the branch practice be able to drop off prescription requests at a local pharmacy in Hale. This had been introduced and a daily collection of the prescriptions introduced.
- Staff told us how the service worked with stakeholders to improve performance.

**Continuous improvement and innovation**

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The provider told us about the awards they had won for innovation. This included an award for producing an Early Years fact sheet which was sent to new parents providing health and support information such as vaccination schedules, breast feeding and signposting to support services. The provider had developed a "text to cancel" service which allowed patients to cancel unwanted appointments, improve access and reduce missed appointments. This was awarded a GP Enterprise Award from the Royal College of General Practitioners (RCGP).
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Regular staff meetings were held to discuss the operation of the service and where improvements could be made.
- The practice was aware of the challenges it faced such as workforce and premises. The provider told us that they were working with the Clinical Commissioning Group (CCG) and Patient Participation Group (PPG) to ensure the practice remained viable for the future. This included consultation about the relocation of the main site and the sustainability of the branch practice. The provider had taken action to improve GP continuity at the practice and it had its own locum GPs (the provider had recruited a team of GPs referred to as bank GPs who could provide short term cover at their practices) and so could deploy GPs familiar with the practice.