Willow Wood Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Outstanding
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

We carried out an announced comprehensive inspection at Willow Wood Surgery on 9 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, caring and responsive services and outstanding for providing effective services. It was also good for providing services for the following population groups older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia).

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs. For example the practice was part of a CCG supported scheme to reduce the number of hospital attendance and admissions for patients living in residential and nursing homes. Data provided by the GP lead showed from that for year 2011/12 to year 2012/13 there had been a 76% reduction in patients being admitted to hospital from the accident and emergency unit of the local hospital.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice was instrumental in developing an initiative to improve care over the winter months (2014/15) and to reduce hospital admissions. This initiative provided an early intervention scheme to allow patients to be seen at home earlier in the morning and a paediatric centralised clinic to support parents to access GPs and nurses rather than attending accident and emergency departments. The initiative also increased access to GP services around high demand periods such as Easter.
- The practice had introduced a new system whereby patients hospital discharge summaries were triaged daily by one of the practice nurses with anything that required action referred to the GPs. This system had recently been reviewed and showed that GPs were now reviewing and actioning approximately 40% of the total number of discharge summaries. This allowed them to provide more appointments.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice carried out a range of clinical audits to evaluate the operation of the service. For example, the initial audit of those patients with atrial fibrillation led to changes in the prescribing practices of the GPs. The second cycle of this audit showed that the practice had improved outcomes for patients and had exceeded the standard set by NICE with regard to the appropriate use of anti-coagulation treatment for patients with atrial fibrillation.

The practice worked effectively with health and social care services to promote patient care. For example the practice was part of a CCG supported scheme to reduce the number of hospital attendance and admissions for patients living in residential and nursing homes. This scheme involved supporting patients and their carers with detailed care plans and the opportunity to meet with the named GP at regular intervals. The scheme also supported GPs to meet with and offer support and education to the nursing home staff to reduce hospital admissions and to support patients to remain at home. Data provided by the GP lead showed from that for year 2011/12 to year 2012/13 there had been a 76% reduction in patients being admitted to hospital from the accident and emergency unit of the local hospital. The scheme had been so successful other practices within the CCG were considering adopting it. A further example was the GP lead was also the Director of the Vale Royal GP Alliance and was instrumental in developing an initiative to improve care over the winter months (2014/15) and to reduce hospital admissions. This initiative provided an early intervention scheme to allow patients to be seen at home earlier in the morning and a paediatric centralised clinic to support parents to access GPs and nurses rather than attending accident and emergency departments. The initiative also

Summary of findings

increased access to GP services around high demand periods such as Easter. This initiative provided patients with an improved service and provided the local health economy of approximately £381000 of savings.

The practice worked effectively with health and social care services to promote patient care. Patients care needs were assessed and care and treatment was being considered in line with best practice national guidelines. There was good communication between staff and staff felt appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with sensitivity, kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example GPs attended neighbourhood meetings to ensure they were aware and involved with any issues and initiatives identified within their local area. A further example was the involvement of the practice in the winter initiatives to provide early intervention services during high demand periods and to reduce attendance at A&E departments and the number of hospital admissions.

Are services well-led?

Good

The practice is rated as good for providing well led services. There was a clear leadership structure in place. Quality and performance were monitored. Staff told us they could raise concerns, felt they were listened to, felt valued and well supported.The practice had an active Patient Forum and Patient Participation Group and other systems to seek and act upon feedback from patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example The practice was part of a scheme to improve care given to patients living in residential and nursing homes. Highlights of this scheme included once or twice weekly proactive ward rounds at the homes, an extensive care plan which included preferred priorities of care, assessment of capacity, usual health and plans for future care.

The practice had a designated named GP for patients who are 75 and over and care plans were in place for these patients.

The practice was involved in the development of local integrated care teams

Drop in clinics for vaccinations were advertised in the reception for all patients but at risk patients were sent specific letters to advise them of the need to have the vaccination. There was information available to patients about services offered within the local community including those patients who may be experiencing social isolation.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were systems in place for call and recall of patients for annual reviews. Patients with long term conditions had alerts placed on their records to ensure they were offered longer appointments with the GP. Patients with multiple problems were able to have all conditions reviewed in one appointment. There was a system in place to ensure that annual blood tests were arranged via the computer system to ensure those patients not attending were identified.

Long term conditions clinics worked to local and national guidelines, and used computerised templates. Queries or concerns from clinics were raised with the GP on the day, and there was an open door approach to sharing problems and learning. Weekly clinical meetings enabled shared problem solving, difficult case review and the discussion and adoption of updated guidelines. Recent examples of this included audits on improving heart failure management and changes to management of atrial fibrillation to reduce stroke risk.

Summary of findings

The practice had achieved and implemented the Gold Standards Framework for end of life care. Gold Standards Framework meetings were held alongside multi-disciplinary meetings every month where the needs of patients with terminal illnesses and complex health needs were discussed. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. All new mothers were sent a letter advising them how to access services for mother and baby. The staff were responsive to parents' concerns about their child's health and prioritised appointments for children presenting with an acute illness. There was a system in place to follow up babies who had not been immunised and there was also an escalation procedure to GPs if this remained a concern. Staff were knowledgeable about child protection and a GP took the lead for safeguarding. Staff put alerts onto the patient's electronic record when safeguarding concerns were raised. Regular liaison took place with the health visitor to discuss any children who were at risk of abuse and to review if an appropriate level of GP service had been provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was open Monday 8am to 8pm and 8am to 6:30pm Tuesday to Friday. The practice offered on the day appointments and telephone consultations. The practice offered on line prescription requests. The practice offered health promotion and screening that reflected the needs for this age group such as smoking cessation, sexual health screening and contraceptive services. Health checks were offered to patients who were over 45 years of age to promote patient well-being and prevent any health concerns.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice was aware of patients in vulnerable circumstances and ensured they had appropriate access to health care to meet their needs. For example, register of carers was maintained to ensure support needs and appropriate referrals were made or offered. Patients' electronic records contained alerts for staff regarding patients requiring

additional assistance in order to ensure the length of the appointment was appropriate. Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training in this.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of 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 an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry as needed. Telephone consultations and the triage service provided support to patients suffering from extreme anxiety and phobias.The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

Summary of findings

What people who use the service say

We received six CQC comment cards and spoke with two patients. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Patients told us that they were treated with care and respect and that GPs were sensitive to their needs.

The latest national GP patient survey results showed that in January 2015, approximately 87% of patients described their overall experience of this surgery as good and 75% were satisfied with the surgery's opening hours and these were higher ratings than other practices in the area. Results from the national GP patient survey also showed that approximately 91% of patients said they had confidence and trust in the last GP they saw or spoke to and approximately 89% said the last GP they saw or spoke to was good at giving them enough time. Both results were in line with practices in the area.

Outstanding practice

- The practice was part of a CCG supported scheme to reduce the number of hospital attendance and admissions for patients living in residential and nursing homes. This scheme involved supporting patients and their carers with detailed care plans and the opportunity to meet with the named GP at regular intervals. The scheme also supported GPs to meet with and offer support and education to the nursing home staff to reduce hospital admissions and to support patients to remain at home. Data provided by the GP lead showed from that for year 2011/12 to year 2012/13 there had been a 76% reduction in patients being admitted to hospital from the accident and emergency unit of the local hospital. The scheme had been so successful other practices within the CCG were considering adopting it.
- The GP lead was also the Director of the Vale Royal GP Alliance and was instrumental in developing an initiative to improve care over the winter months (2014/15) and to reduce hospital admissions. This initiative provided an early intervention scheme to allow patients to be seen at home earlier in the morning and a paediatric centralised clinic to support parents to access GPs and nurses rather than attending accident and emergency departments. The initiative also increased access to GP services around high demand periods such as Easter. This initiative provided patients with an improved service and provided the local health economy of approximately £381000 of savings.
- The practice had introduced a new system whereby patients hospital discharge summaries were triaged daily by one of the practice nurses with anything that required action referred to the GPs. This system had recently been reviewed and showed that GP were now reviewing and actioning approximately 40% of the total number of discharge summaries. This allowed them to provide more appointments.

Willow Wood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector, an inspection manager and a GP specialist advisor.

Background to Willow Wood Surgery

Willow Wood Surgery is based in Winsford Cheshire, the practice moved to its current site in 2001.

The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, two salaried GPs, two practice nurses, a practice manager and administrative and reception staff. The practice is a training practice and has GP registrars working with them as part of their training and development in general practice.

The practice is open Monday 8am to 8pm and 8am to 6:30pm Tuesday to Friday. All appointments are bookable on the day with a triage system in place that ensures all patients receive a telephone consultation with the GP prior to an appointment being offered. The practice also provides home visits to patients who are housebound or too ill to attend the practice. The practice closes one afternoon per month for staff training. When the practice is closed patients access East Cheshire Trust for primary medical services.

The practice is part of Vale Royal Clinical Commissioning Group (CCG). It is responsible for providing primary care services to approximately 6,121 patients and the practice has a General Medical Services (GMS) contract.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people

Detailed findings

- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 9th June 2015.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example an emergency drug that had a recently expired usage date was given to a patient with the consent of the accompanying parent. The GP raised this as a significant event and following an investigation and analysis the roles and responsibilities with regard to the auditing of the emergency drugs and the location they were stored was made clear to all clinicians. The analysis also identified what went well to enable shared learning across the practice.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Staff were encouraged to complete significant event reporting forms via the practice's computer system. The practice held meetings at which significant events were discussed in order to cascade any learning points. We viewed analysis documentation which included details of the events, details of the investigations, learning outcomes including what went well and what could be improved. For example delays in the referral system to secondary health services had been identified. Following the investigation learning outcomes had been identified and a change to how referrals were managed and processed had been put into place.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook on-going audits to ensure best practice.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. The senior partner was the lead for safeguarding.

All staff had received safeguarding children training at a level suitable to their role for child protection, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended child protection meetings and when possible safeguarding adult meetings. The practice always provided reports for other agencies.

The practice had a computer system for patients notes and there were alerts on a patient's record if they were at risk or subject to protection. The lead GP liaised with health and social care professionals to discuss children and adults who may be at risk.

A chaperone policy was available on the practice's computer system. The practice nurses acted as chaperones.

Medicines management

The practice worked with pharmacy support from the local CCG. Regular medication audits were carried out with the support of the pharmacy team to ensure the practice was prescribing in line with best practice guidelines. The computer system used triggered annual medication review dates for patients and these were followed up by the GPs and practice nurses.

The practice had two fridges for the storage of vaccines. One of the practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

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

Good

Are services safe?

Emergency medicines were available in an emergency drugs bag that included colour coded drugs to treat conditions such as chest pains, asthma and anaphylaxis. These were stored securely and available in the treatment room. One of the practice nurses had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building including the waiting area. Clinical waste disposal contracts were in place and a spillage kit was available.

One of the practice nurses was the designated clinical lead for infection control. There was an infection control policy in place. The practice nurses received regular infection control training and updates from an external organisation that provided infection control support and advice. There were infection control audit systems in place including cleaning schedules and on-going monitoring of the cleaning contract with an external company. The practice manager told us she was in the process of reviewing and updating the cleaning schedules.

The practice had a service level agreement with the premises landlord to ensure that the testing for Legionella (a bacterium which can contaminate water systems in buildings) was carried out at regular intervals. We saw records that confirmed the practice monitored the testing carried out to reduce the risk of infection to staff and patients.

Equipment

All electrical equipment was checked to ensure the equipment was safe to use. Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order. One of the practice nurses carried out regular checks on emergency equipment such as the defibrillator.

Staffing and recruitment

Staff told us there were enough staff to meet the needs of patients and they covered each other in the event of unplanned absences.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (these checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring safety and responding to risk

The practice was a purpose built building that Willow Wood Surgery shared with other primary care services. The practice manager was the lead for health and safety and was responsible for the compliance with fire and other health and safety regulations for the premises.

There were procedures in place for monitoring and managing risks to patient safety and the practice had recently implemented a risk register that was monitored by the practice manager and the senior partner. Issues identified on the risk register were discussed at practice meetings. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. There was a health and safety policy available for all staff. The practice had recently carried out a fire drill.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

defibrillator available on the premises and oxygen. There was a first aid kit and accident book available. There was a formal medical emergency protocol in place and when we discussed medical emergencies with staff, they were aware of what to do.

The practice had a disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do if faced with a major incident. The practice manager told us she was in the process of reviewing and updating this document.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the practice nurses carried out health checks which included reviewing information about the patient's individual lifestyle as well as their medical conditions. Patients were able to discuss their needs and be introduced to what services were available in order to make best use of the practice. The practice nurses referred the patient to the GP if the patient was taking any medication or when a new patient had complex health needs.

Clinical staff we spoke with told us how they accessed best practice guidelines to inform their practice. Clinical staff attended regular training and educational events provided by the Clinical Commissioning Group and they had access to recognised good practice clinical guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines on their computers. The GPs met weekly to discuss new clinical protocols, review complex patient needs and keep up to date with best practice guidelines, clinical research and relevant legislation.

The practice had introduced a new system whereby patients hospital discharge summaries were triaged daily by one of the practice nurses with anything that required action referred to the GPs. This system had recently been reviewed and showed that GP were now reviewing and actioning approximately 40% of the total number of discharge summaries. This allowed them to provide more appointments. The practice nurse also ensured the discharge summary information was coded correctly and entered onto the patient records to support effective monitoring of patients to ensure that all their needs were continuing to be met.

The GPs used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks. The practice had changed the referral system to ensure that one member of staff had overall responsibility to ensure referrals were made and tracked. This included the medical secretary spending time with each GP to support them with the referral process.

The practice was part of a CCG supported scheme to reduce the number of hospital attendance and admissions for patients living in residential and nursing homes. This scheme involved supporting patients and their carers with detailed care plans and the opportunity to meet with the named GP at regular intervals. The scheme also supported GPs to meet with and offer support and education to the nursing home staff to reduce hospital admissions and to support patients to remain at home. Data provided by the GP lead showed from that for year 2011/12 to year 2012/13 there had been a 76% reduction in patients being admitted to hospital from the accident and emergency unit of the local hospital. The scheme had been so successful other practices within the CCG were considering adopting it.

The GP lead was also the Director of the Vale Royal GP Alliance and was instrumental in developing an initiative to improve care over the winter months (2014/15) and to reduce hospital admissions. This initiative provided an early intervention scheme to allow patients to be seen at home earlier in the morning and a paediatric centralised clinic to support parents to access GPs and nurses rather than attending accident and emergency departments. The initiative also increased access to GP services around high demand periods such as Easter. These initiative provided patients with an improved service and provided the local health economy of approximately £381000 of savings.

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

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There were systems in place to evaluate the operation of the service and the care and treatment given. The practice

had a system in place for completing clinical audit cycles. We saw that audits of clinical practice were regularly undertaken and that these were based on best practice national guidelines. Examples of clinical audits seen included an audit of the clinical management of acute tonsillitis and the assessment of stroke and bleeding risk and interventions to prevent stroke in patients with atrial fibrillation. Both audits led to changes to how the practice operated to meet patients' health care needs. For example, the initial audit of those patients with atrial fibrillation led to changes in the prescribing practices of the GPs. The second cycle of this audit showed that the practice had improved outcomes for patients and had exceeded the standard set by NICE with regard to the appropriate use of anti-coagulation treatment for patients with atrial fibrillation.

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. For example. All the clinicians participated in clinical audits. We discussed audits with GPs and found evidence of a culture of communication, sharing of continuous learning and improvement.

The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions.

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed better than average in maintaining a register for patients with high blood pressure, a register of all patients in need of palliative care/ support and having regular multidisciplinary reviews of patients on the palliative care register and ensuring patients with schizophrenia, bipolar affective disorder and other psychoses have had a comprehensive, agreed care plan documented in the record, in the preceding 12 months.

Effective staffing

An appraisal policy was in place. We spoke to four reception/administrative staff and a nurse who told us the practice was supportive of their learning and development needs. We spoke with three GPs they told us they had annual appraisals. GPs told us they had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development. Revalidations of all the GPs had taken place. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) that their knowledge is up to date, they are fit to practise and are complying with the relevant professional standards.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. For example, the practice closed one afternoon per month to attend either CCG led learning events or for in-house meetings and to provide time for staff development. The clinical staff met to discuss new protocols, to review complex patient needs and keep up to date with best practice guidelines. The reception and administrative staff met to discuss their roles and responsibilities and share information. GPs met informally to discuss patient needs and provide peer support. Partners and practice manager meetings took place to look at the overall operation of the service.

The practice manager maintained a record of mandatory training carried out by all staff and role specific training for reception/administration staff and was in the process of expanding the training record to incorporate role specific training for the practice nurses. The training record showed that they had completed mandatory training such as safeguarding adults and children and training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). They had also undertaken role specific training, such as infection control training and information governance. Some records showed that training updates were due and the practice manager had a plan in place to

address this. The GPs kept a record of their own clinical training. On discussion with the GPs it was evident that they kept their skills and knowledge up to date. Clinical and non-clinical staff told us they had the training they needed to support them in their roles.

Working with colleagues and other services

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

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

GPs were invited to attend reviews of patients with mental health needs and child and vulnerable adult safeguarding conferences. The lead GP told us that they attended child protection meetings and adult safeguarding meetings, however if this was not possible they provided a report detailing their involvement with the patient. The safeguarding lead met with the health visitor to discuss any needs or concerns about children and young people registered with the practice. The practice worked with mental health services to review care and share care with specialist teams.

The lead GP told us they had federated with 11 other GPs within the CCG area and worked with them to improve the range and quality of services provided. They also told us they attended monthly neighbourhood meetings which were attended by other GP practices, social services, the local mental health team for older people, community matrons, district nurses, physiotherapist and occupational therapist. This meeting had encouraged better communication and closer working relationships between health and social care services.

The practice particularly the practice nurses looked after the healthcare needs of a small travelling community and supported them to access other health services.

Information sharing

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

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

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

The practice had an effective system in place to ensure referrals to acute services were timely and monitored by the practice.

Consent to care and treatment

We spoke with the GPs and the practice nurse about their understanding of the Mental Capacity Act 2005 and Gillick guidelines. GPs and the nurse practitioner demonstrated an awareness of the Mental Capacity Act and when best interest decisions needed to be made. GPs and the nurse practitioner were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice sought consent for those patients who had minor surgery such as joint injections or contraceptive implants and recorded this consent in patients records.

Health promotion and prevention

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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. Quality and Outcomes Framework (QOF) information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions. The practice performed better than the national average in ensuring patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at six CQC comment cards that patients had completed prior to the inspection and spoke with six patients. Patients were very 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 we spoke with told us they had enough time to discuss things fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in January 2015 (from 119 respondents) found that approximately 88% of patients said the last time they saw or spoke to a GP, the GP was good or very good at treating them with care or concern this was higher than the CCG average. Approximately 73% said the last time they saw or spoke to a nurse the nurse was good or very good at treating them with care or concern this was in line with the CCG average. Eighty seven percent of patients who responded to this survey described the overall experience of their GP surgery as good which was higher than the CCG average.

The practice used a range of systems in 2014/15 to gain feedback from patients including targeted telephone and in house surveys, the friends and family survey and Cheshire West Health Watch (GP Access Project Patients) Questionnaire. Results from these surveys indicated that patients satisfaction with the quality of consultations, accessing services and overall satisfaction with care received had increased. For example satisfaction with access to services had had increased by 22% from December 2013 to January 2015.

We observed that privacy and confidentiality were maintained for patients using the service on the day of the visit. Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was an area available if patients wished to discuss something with them away from the reception area. We observed this facility being offered and used by patients during the inspection visit.

We observed that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the National GP Patient Survey in January 2015 showed approximately 84% of respondents said the GPs were good at involving them in decisions about their care and 68% felt the nurses were good at involving them in decisions about their care. Both results were higher than the CCG average.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received.

Patient/carer support to cope emotionally with care and treatment

Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included information for carers, information about the Citizen's Advice Bureau, advocacy services, mental health support services and relationship support services.

Staff spoken with told us that bereaved relatives known to the practice were offered support following bereavement. GPs and the practice nurse were able to refer patients on to counselling services for emotional support, for example, following bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Staff we spoke with told us how they responded to the differing needs of patients. We spoke to four members of the Patient Participation Group who had worked with the practice for over three years. They told us that working with the practice had resulted in significant change in how services were provided. For example patients had raised issues about the difficulties in getting an on the day appointment with a GP and the difficulty of getting through on the telephone. This issue was raised with the practice and resulted in a change in the appointment system. The new system guaranteed that when a patient rang the practice they would be offered a telephone consultation and an on the day appointment if needed. The Patient Participation Group also told us that they had arranged coffee mornings to highlight the services offered by the practice.

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

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

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

The practice offered patients a chaperone prior to any examination or procedure. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice nurses acted as the chaperones.

The practice had a long-standing, active Patient Participation Group. The purpose of the Patient Participation Group was to meet with practice staff to review the services provided, develop a practice action plan, and help determine the commissioning of future services in the neighbourhood. Records showed how the Patient Participation Group had been consulted over the type of questions to include in the patients survey. Records and a discussion with representatives from the Patient Participation Group indicated how they had worked with the practice to make improvements to access to services and communication with patients.

Tackling inequity and promoting equality

The surgery had access to translation services and proactively engaged with them to ensure whenever possible a translator could attend consultation with patients. The practice had also offered to financially support staff to learn a second language to further support patients whose first language was not English.

The practice engaged with local services to ensure patients had access to advice and support with regard to health, housing and social issues such as addiction issues, sexual health education and social care needs and supported older patients to access services to reduce social isolation.

The building had appropriate access and facilities for disabled people including disabled parking. There was an audio induction loop available for patients with reduced ranges of hearing.

The practice had an equal opportunities policy which was available to all staff on the practice's computer system. Staff spoken with indicated they had received training around equality, diversity and human rights.

Access to the service

The practice opened between 8am to 8pm Monday and 8am to 6:30pm Tuesday to Friday. The practice operated a same day appointment system with GPs using the initial telephone consultation to triage patients. During the telephone consultation the GP would discuss with the

Good

Are services responsive to people's needs?

(for example, to feedback?)

patient whether they needed to be seen that day or at a more convenient time for the patient. The appointment system allowed GPs flexibility so they could spend longer with patients if they required more time at an appointment.

Results from the GP national Patient survey from January 2015 showed that approximately 54 % of patients stated that they usually get to see or speak to the GP they prefer. This result was in line with the CCG average.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. We discussed with the practice manager the need to slightly amend the complaints policy to ensure that it was in line with recognised guidance and contractual obligations for GPs in England. The practice manager agreed to make the amendment.

Information about how to make a complaint was available in the waiting room and in the practice leaflet. The complaints policy clearly 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 and written apologies were given.

The practice kept a complaints log and recorded verbal as well as written complaints. The practice reviewed the complaints received on an annual basis to identify any trends in issues which would require any improvements. We looked at how three complaints were managed and found they had been appropriately managed and lessons had been learned from them.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had clear aims and objectives which included, providing a high-quality, patient-led primary health-care service, involving patients in all aspects of their health care, providing a timely response to both acute and long-term conditions, ensuring patients saw the most appropriate clinical member of staff and communicating effectively with other health-care providers from both primary, secondary and community care settings and to participate.

The patient charter provided information to patients about the service they should expect to receive this was available on the practice website aims and objectives were available in the statement of purpose for the practice which was available on request. Staff we spoke with were able to articulate the vision and values of the practice.

Governance arrangements

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

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

The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance. The GPs and nursing staff 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.

Leadership, openness and transparency

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

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at staff meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed. Staff told us they could raise concerns and felt they were listened to. Regular governance meetings took place to share information and to look at what was working well and where any improvements needed to be made.

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

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

Results of surveys and complaints were discussed at practice meeting and clinical meetings. There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with four members of the PPG who told us the PPG felt that the practice was responsive to any issues raised by the group. They told us that the practice was very patient centred and had involved them in any proposed changes to the service.

Management lead through learning and improvement

The practice worked well together as a team and held meetings for team learning and to share information. There were regular formal clinical meetings with set agendas

Are services well-led?

Good

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

covering all aspects of patient safety. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and ensured the whole team was involved in driving forward improvements. They recognised future challenges and areas for improvement.

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