Penketh Health Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Penketh Health Centre on 19 May 2015. Overall the practice is rated as good.

Penketh Health Centre provided safe, effective, responsive care that was well led and addressed the needs of the population it served.

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

- Systems were in place to ensure incidents and significant events were identified, investigated and reported. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons learnt from the investigation of safety incidents were disseminated to staff. Infection risks and medicines were managed safely.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Patients experienced clinical outcomes that were in line with or above the national average.
- Patients spoke highly of the practice. They said they were treated with compassion, dignity and respect and they were involved in decisions about their treatment.
- The practice provided care to its population that was responsive to their health needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- There was a clear leadership structure, staff enjoyed working for the practice and felt well supported and valued. The practice monitored, evaluated and improved services. The practice proactively sought feedback from staff and patients, which it acted on.

There was an area of practice where the provider needs to make improvements.

The provider should:

- Improve access to appointments by reviewing the appointment system.

Summary of findings

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 learnt and communicated to all staff to support improvement. Child and adult safeguarding was well managed, staff were trained and supported by knowledgeable safeguarding lead members of staff. Medicines and infection control risks were managed safely. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were around average for the locality, including the Quality and Outcomes Framework (QOF). The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. The practice had achieved a score of 96% for QOF last year (this was higher than the national average). Staff referred to and used guidance from National Institute for Health and Care Excellence (NICE). The practice had identified the specific needs of their patients and was proactive in assessing and planning care particularly for older, vulnerable patients, those living in care homes and those with long term and mental health conditions. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and demonstrated knowledge and skills required to care for their patient population.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey, patients we spoke with and those who completed the CQC comment cards were complimentary and positive about the service and the care and treatment they received. Patients said staff were professional and they were treated with compassion, dignity and respect. They felt confident in the abilities of staff, were given full explanations, time to ask questions and were involved in decisions about their care and treatment. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality. We also observed that staff treated patients with dignity and respect.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had identified and reviewed the needs of their local population and provided tailored services accordingly. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Information about how to complain was available and evidence showed that the practice responded appropriately to issues raised with learning and improvements implemented as a result. However concerns were raised regarding the appointment system. Some patients said they experienced difficulty getting through to someone at the practice on the phone and getting an appropriate and convenient appointment, whilst others expressed concern that appointments often ran over time.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and values for care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular clinical and team meetings. The practice proactively sought feedback from staff and patients. Staff received inductions, appraisals and attended staff meetings and learning and development events.

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 had a higher than national average number of patients aged over 65. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the Quality and Outcomes Framework (QOF) information indicated that last year 70% of patients aged 65 and older had received a seasonal flu vaccination. 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, avoiding unplanned admissions, seasonal flu vaccinations and in dementia and end of life care. It was responsive to the needs of older people, and offered home visits to deliver care to those older patients who were not able to attend the surgery. The practice provided a service to five care homes locally to assess, review and treat patients with the aim of reducing avoidable admissions to hospital.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than national average number of patients with long standing health conditions 58% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition. For example 100% of patients with rheumatoid arthritis had received an annual review and 100% of patients with chronic pulmonary obstructive disease (COPD) had received a review in the last 12 months.

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patients with long term conditions effectively. The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected and above the national average. For example, patients with asthma had received a review in the last 12 months regular and clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations that were on target for QOF. Patients at

Summary of findings

risk of unplanned admissions to hospital were reviewed and data on accident and emergency admissions were reviewed to consider appropriateness of care and treatment given by the practice and whether the admission could have been avoided.

The clinical staff managed chronic long term conditions and diseases. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, the practice maintained a register of children who had a child protection plan. Immunisation rates were above national average for standard childhood immunisations. We received positive feedback regarding care and treatment at the practice for this group. Patients we spoke with told us they were confident with the care and treatment provided to them. Appointments were available outside of school hours and the premises were suitable for children and babies including the provision of breast feeding and baby changing rooms. The practice responded to the needs of this group and children or young people were always given a same day appointment or urgent appointment as necessary.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered flexibility in appointments with extended hours offered two days per week and a range of services such as health promotion and screening that reflected the needs for this age group. For example smoking cessation and travel advice. Routine health checks were available to patients aged over 45. Online booking, cancellation of appointments and ordering of repeat medications facilities were available. Short message service (SMS) text messaging was used to remind patients of their appointments and to help reduce non-attenders.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including children and adults at risk of abuse, patients with dementia, terminally ill and those with a learning disability. It had carried out annual health checks for people with a learning disability and it offered longer appointments for vulnerable patients. Patients on the palliative care register were highlighted and offered priority appointments if needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It was able to signpost vulnerable patients and their carers to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). One hundred percent of people experiencing poor mental health had an agreed documented care plan and 82% of those diagnosed with dementia had received a review of their care in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice worked with the mental health services in Warrington. The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations including MIND. Patients with poor mental health were accommodated, where possible, with same day appointments with a preferred clinician. Some of the staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection and received 15 completed CQC comment cards. Patients whom we spoke with varied in age and population group.

All patients were positive about the practice, the staff and the service they received. They told us staff were caring, and compassionate and that they were always treated well with dignity and respect.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 96% of respondents saying they had confidence and trust in the last GP they saw or spoke with. Eighty six percent said the last GP they saw or spoke to was good at treating them with care and concern, 88% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Eighty eight percent said the last GP they spoke to or saw was good at listening to them, whilst 87% said the GP was good at explaining treatment and tests. The data demonstrated the practice was performing above or around average for the majority of questions asked.

Some patients that we spoke with and from comments cards reviewed expressed concern regarding accessing appointments. They told us they found it difficult to get through to the practice to make an appointment by telephone and felt they needed to attend the practice in order to get a suitable appointment. Patient's told us that when they did eventually get through by telephone then all that's days appointments were taken. This was collaborated by the national GP patient survey (2014) which said the practice could improve on getting through to the practice by phone. Only 34% of respondents said they found it easy to get through by phone, compared to the local CCG average of 61%. Forty five percent described their experience of making an appointment as good, and only 40% with a preferred GP said they usually got an appointment or spoke with that GP. (This was below the local CCG average).

Patients told us they considered that the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Improve access to appointments by reviewing the appointment system.

Penketh Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Penketh Health Centre

Penketh Health Centre is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 15200 patients living in the Penketh and Great Sankey areas of Warrington. The practice is situated in a purpose built health centre. The practice has ten GPs (four male and six female), a practice management team, practice nurses, administration and reception staff. Penketh Health Centre holds a General Medical Services (GMS) contract with NHS England.

The practice is open during the week, between 8.30am (8am for emergency appointments) and 6.30pm with extended hour's appointments available on Mondays and Wednesdays until 8.30pm.They are closed one half day per month for staff training and development. Patients can book appointments in person, via the telephone or online. SMS text messages are available as reminders for appointments. The practice provides telephone consultations, pre bookable consultations, urgent consultations and home visits. The practice treats patients of all ages and provides a range of primary medical services.

The practice is part of Warrington Clinical Commissioning Group (CCG) and is situated in an affluent area. The practice population is made up of a higher than national average older population. Fifty eight percent of the patient population has a long standing health condition and there is a lower than national average number of unemployed patients.

The practice does not provide out of hours services. When the surgery is closed patients are directed to phone NHS 111 or the local out of hour's service provider for help.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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 (Regulated Activities) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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 and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service.

We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face, looked at survey results and reviewed comment cards left for us on the day of our inspection.

We spoke with the practice management, registered manager, GPs, practice nurses, administrative and reception staff on duty. We spoke with patients who were using the service on the day of the inspection.

We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how GPs made clinical decisions and reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

Warrington Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. The practice 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, concerns and near misses. GPs and nurses told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

Learning and improvement from safety incidents

We reviewed the records of significant events that had occurred during the previous 12 months. There was evidence that appropriate learning had taken place and that findings were disseminated to relevant staff through one to one discussions, staff meetings and via email. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so. Staff had received update training in the significant event policy and procedures. We saw that the practice carried out an overview of significant events twice a year to identify themes or trends. All staff were involved in feedback and lessons learnt from incidents and complaints by attending regular team meetings at which these were discussed. Minutes from the meetings were distributed to all staff.

The practice showed us the system they used to manage and monitor incidents. We tracked some incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of documented action taken as a result and implementation of learning. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. For example we saw evidence of the recent guidance on Ebola displayed on the website and in the practice. (Ebola is a contagious viral infection causing severe symptoms and caused an epidemic in West Africa). We also saw evidence of action taken in response to the guidance of the use of window blinds. We were told that alerts were discussed at team meetings or disseminated via email to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to safeguard vulnerable children, young people and adults. The practice had up to date safeguarding child and adult policies and procedures in place. They provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were available to staff on the practice computer system. Staff had access to contact details for both child protection and adult safeguarding teams. We saw these contact details displayed in clinical and non-clinical areas.

We looked at the training/staff skills competencies matrix which showed that all staff had received relevant role specific training in safeguarding. Clinical staff had an appropriate higher level of training (level three) than non-clinical staff. Staff we spoke with were knowledgeable about the types of abuse and how to raise concerns or report incidents. Staff were able to discuss examples of at risk children and vulnerable patients and how they were cared for.

The practice had a dedicated GP lead in safeguarding. They had attended appropriate training to support them in carrying out their work, as recommended by their professional registration safeguarding guidance. They were knowledgeable about the contribution the practice could make to multi-disciplinary child protection meetings and

serious case reviews. The safeguarding lead could not attend every safeguarding conference they were invited to due to time constraints; however they completed all requested reports for child protection and serious case review meetings. All staff we spoke to were aware that the practice had a safeguarding lead and knew who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. Codes and alerts were applied on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were flagged and reviewed. The clinical staff were fully aware of the vulnerable children and adult patients at the practice and discussed them at regular clinical meetings internally and at multi-disciplinary safeguarding meetings.

The practice had a current chaperone policy. (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). However we noted that the chaperone policy notice was not prominently displayed in the practice but was described in the practice leaflet.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and temperature sensitive medicines. We saw that checks were carried out on the fridge temperatures to ensure the fridge remained at a safe temperature. We spoke to staff who managed the vaccines; they had a clear understanding of the actions they needed to take to keep vaccines safe. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. We noted that the fridges used to store vaccines and other medicines were not hard wired however they did have warning notices displayed to alert people not to inadvertently unplug them.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

Repeat prescriptions were held securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Medicines for use in medical emergencies were kept securely in the office. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis.

The practice staff and GPs were supported by the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends.

Cleanliness and infection control

The patients we spoke with commented that the practice was clean and appeared hygienic. We looked around the premises and found them to be clean, tidy and well maintained. The treatment rooms, waiting areas and toilets were in good condition. Staff had access to gloves and aprons and there were appropriate segregated waste disposal systems for clinical and non-clinical waste. We observed hand washing facilities were suitable to promote good standards of hygiene. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms, couches were washable and clean and we saw evidence that the curtains in clinical rooms were renewed on a regular basis.

The practice had a nurse lead for infection control. Evidence demonstrated infection control training and annual updates were undertaken by all staff. Staff understood their role in respect of preventing and controlling infection. For example, reception staff could describe the process for dealing with submitted specimens. Procedures for the safe storage and disposal of needles and waste products were evident in order to protect the staff and patients from harm.

The practice had an infection control audit carried out by the community infection control team in 2014. We saw the completed report; the practice had scored 98%. There was evidence of an action plan, in progress and nearly complete, to address the minor issues found. Cleaning was carried out by a dedicated cleaning team and the cleaning standards and schedule were monitored.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

We found that the practice carried out regular testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. There were contracts in place for regular checks of fire extinguishers and portable appliance testing (PAT). All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that annual calibration and servicing of medical equipment was up to date, for example weighing scales, spirometers and blood pressure measuring devices.

We saw that the emergency equipment was suitably stored and included nebulisers, oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available within the practice also. These were maintained and checked regularly.

Staffing and recruitment

There was an up to date recruitment policy in place. This was in line with current guidance and regulations and was sufficient to ensure a suitable process was in place for safe recruitment of staff.

We looked at seven staff files including clinical and non-clinical staff. We found that overall these contained all the required information relating to workers. We found that a Disclosure and Barring Service (DBS) check had been undertaken for all staff at a suitable level for their roles (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post).

Chaperone training had been undertaken by some of the reception and administrative staff and we saw evidence that these staff had a suitable DBS check in place.

Records demonstrated clinical staff's professional registration with the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) were monitored and checked regularly. GPs were checked to ensure they were suitable to work in their role and that they were on the NHS England Performers List. This included checking any locum GPs used.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased activity and demand.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, medicines management, staffing and dealing with emergencies and equipment. The practice had a health and safety policy in place. Health and safety information was displayed for staff to see. Risk assessments were in place for general environmental risks, Control of Substances Hazardous to Health (COSHH) and fire risks.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system. Historic paper records were stored securely on site.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: ill children and young people were usually given an appointment the same day or directed to appropriate health services where needed.

Arrangements to deal with emergencies and major incidents

A current disaster recovery and business continuity plan was in place. The plan covered business continuity, staffing, records, electronic systems, clinical and environmental events. The document contained relevant contact details for staff to refer to. Staff we spoke with were aware of the business continuity plan.

The practice had arrangements in place to manage emergencies. Staff could describe how they would alert

Good

Are services safe?

others to emergency situations via the electronic systems on their computers. Staff were up to date with their training in basic life support and received regular (six monthly) update training in the use of the emergency equipment. There was emergency equipment and medicines available including an automated external defibrillator and oxygen. Suitable emergency medicines were available in the practice and staff knew of their location.

Records showed that fire fighting equipment and fire safety equipment (such as the fire alarm) were routinely checked and maintained under contract. Staff were up to date with fire safety training, this included regular fire drill practise.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and used current best practice. The staff we spoke with and evidence we reviewed confirmed that care and treatment was aimed at ensuring each patient was given support to achieve the best health outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Clinical Excellence (NICE) and local commissioners' guidelines, assessments and care plans of patients' needs and these were reviewed appropriately.

The GPs and practice nurses told us that they discussed together new clinical protocols, reviewed complex patient needs and kept up to date with best practice guidelines and relevant legislation. The practice nurses supported each other and were well supported by the GPs in clinical decision making. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines. Multi-disciplinary team meetings also demonstrated sharing and evaluation of care and treatment for older people, those with long term conditions, terminally ill patients and vulnerable patients.

The GPs specialised and led in clinical areas such as safeguarding, palliative care and medicines management. They also specialised and took the lead with different patient groups such as family planning, dementia, diabetes and mental health patients. The practice nurses also managed specialist clinical areas such as diabetes, family planning, heart disease, respiratory disease and mental health. This meant that the clinicians were able to focus on specific conditions and provide patients with regular support based on up to date information.

The practice provided a service for all age groups. They provided services for patients with learning disabilities, patients living in care homes, those with long term conditions and patients experiencing poor mental health. We found that staff were familiar with the needs of patients and the impact of the socio-economic environment. Services provided were tailored to meet these needs. For example long term condition reviews were conducted in one extended appointment to cover multi pathology so that all the patients tests/results and treatments were reviewed and delivered at the one appointment. The practice used coding and alerts within the clinical electronic record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The 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.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved a score for QOF of 96% last year which was higher than the national average. QOF information indicated that patients with long term health conditions received care and treatment as expected and around the national average including for example patients with diabetes had regular screening and monitoring, the percentage of patients with diabetes who had received a seasonal flu vaccination was higher than the national average (98%) and clinical risk groups (at risk due to long term conditions) also had good uptake rates for seasonal flu vaccinations. Child immunisations rates were above national average. Uptake of cervical cancer screening was around national average for patients having had a cervical smear in the last 5 years (where relevant).

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients for example the practice kept up to date disease registers for patients who were vulnerable and for those with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). These registers were used to identify and monitor patients' health needs and to arrange annual health reviews.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included

domperidone use, the use of oral non-steroidal anti-inflammatory drugs in patients with multiple myeloma and the treatment of atrial fibrillation with anticoagulation therapy. These were fully completed audits where the practice was able to demonstrate the changes resulting since the initial audit, improved patient outcomes and ensured the practice worked within NICE guidelines.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision, locality and national performance indicators and QOF. For example, the practice participated in the national cancer audit and had audited upper gastro intestinal (GI) endoscopy referrals to assess whether in-house referrals for urgent upper GI endoscopy were consistent with NICE guidance. The medicines management support from the CCG also undertook regular frequent audits of medications and prescribing trends such as a domperidone safety review.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice participated in the Gold Standards Framework (GSF). (GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life, delivered by care providers). The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The patient's care plan and any other relevant information were shared with the out of hours services to inform them of any particular needs of patients who were nearing the end of their lives.

Effective staffing

There was an induction procedure in place which identified the essential knowledge and skills needed for new employees. We spoke with staff who confirmed that they had received an induction. We saw evidence of induction for trainee and GP registrars. There was a study and training policy in place which set out the identification of training and development needs and the support given to staff for continuous professional and personal development.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending essential (mandatory) training such as safeguarding, basic life support skills, infection control and information governance. We saw that the practice maintained an organised record (matrix) of staff training which demonstrated staff compliance against the training policy.

We noted a good skill mix among the doctors with each having special interests in different fields of general practice. GPs undertook continuing professional development for their roles for example, in diabetes, and palliative care. They also undertook various audits, for example, of minor surgery wound infections as part of their on-going appraisals and revalidation.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We noted one of the practice nurses appraisal was out of date and due to be carried out. We spoke to staff who told us the practice was supportive of their learning and development needs. All GPs were up to date with their yearly continuing professional development requirements and they had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice nurses, healthcare assistants and GPs had completed accredited training around checking patients' physical health and around the management of the various specific diseases and long term conditions. Additional role specific training had been undertaken by these clinical staff to support them in these roles. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on family planning, administration of vaccines, phlebotomy and cervical cytology. Those with extended roles (for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice had undertaken a capacity and demand review last year. This demonstrated that at the time there

Good

Are services effective?

(for example, treatment is effective)

was sufficient staffing to meet the patient population demand, however as part of the on-going review of concerns regarding appointments, the practice planned to review staffing and skill mix again.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. We were shown how the practice provided the 'out of hours' service with information, to support, for example, end of life care. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post and we saw that this information was read and actioned by the GPs in a timely manner. Information was also scanned onto electronic patient records in a timely manner.

The practice worked closely with other health and social care providers in the local area. They told us how they worked with the community mental health team, social workers and health visitors to support patients and promote their welfare. The practice held monthly multidisciplinary meetings to discuss the needs of complex patients, for example those with end of life care needs.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hours services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. Electronic systems were in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice has signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. They provided us with examples which demonstrated their understanding around consent and mental capacity issues. They were aware of the circumstances in which best interest decisions may need to be made in line with the Mental Capacity Act when someone may lack capacity to make their own decisions. Some clinical staff had received training in the Mental Capacity Act. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for child immunisations with recorded explanation and consent held in their records. Consent was also documented for joint injections on the electronic patient record.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets and posters in the waiting area about the services available. This included smoking cessation, general lifestyle advice and travel advice. The practice hosted voluntary sector promotional events such as benefits advice, carers support and dementia support.

The practice offered NHS Health Checks to all its patients aged over 40. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for children's immunisations was higher

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Are services effective?

(for example, treatment is effective)

than the national average. Seasonal flu immunisation rates for the over 65 group were around average for the CCG. The practice offered well woman/man checks where appropriate.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. 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. For example, the practice kept a register of all patients with dementia and records showed 82% had received a review in the last 12 months and one hundred percent of people experiencing poor mental health had an agreed documented care plan. The practice had also identified the smoking status of patients over the age of 16 and actively offered smoking cessation advice to these patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality. We noted phone calls were taken away from the reception desk to aid confidentially when taking calls. They offered a separate room away from reception where patients could speak confidentially with staff if necessary.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We observed staff were discreet and respectful to patients. Patients we spoke with told us they were always treated with dignity and respect.

We looked at 15 CQC comment cards that patients had completed prior to the inspection and spoke with five patients. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity, felt they had confidence in the staff caring for them and that their health needs were addressed. 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 2014 found that 86% of patients at the practice stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern, this was higher than the national average. Seventy four percent of patients who responded to this survey described the overall experience of their GP surgery as good or very good (this was slightly lower than the national average).

The practice offered patients a chaperone prior to any examination or procedure. Patients confirmed with us that chaperones were offered regularly and they had used chaperones during examinations, however information about having a chaperone was not seen displayed in the treatment and consultation rooms. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients who we spoke with and who made comments via the CQC comments cards, told us they felt involved in decisions about their own treatment, they received explanations about diagnosis and treatments and staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results.

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 2014 demonstrated 80% of patients said the GPs were good at involving them in decisions about their care and 83% of respondents said the nurses were good at involving them in decisions about their care. These results were above average when compared nationally.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the comment cards we received told us that staff were caring and compassionate.

Patients told us they had enough time to discuss things fully with the GP, they felt listened to and felt clinicians were empathetic and compassionate. Results from the National GP Patient Survey told us that 88% of patients said the last GP they saw or spoke to was good at giving them enough time, 88% said the GP was good at listening to them and 87% said they were good at explaining tests and treatment. These results were above national average.

The practice cared for patients with terminal illness and those coming towards the end of their life. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the

Good

Are services caring?

care plans and support needs of patients and their families. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Staff spoken with told us that bereaved relatives known to the practice were offered support. The practice signposted carers to support led by community services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs. The needs of the practice's population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information and registers about the prevalence of specific diseases within their patient population and patient demographics. This information was reflected in the services provided, for example screening programmes, vaccination programmes, specific services and reviews for elderly patients, those patients with long term conditions and mental health conditions.

We were told the practice engaged with the NHS England Area Team, Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was responsive to the needs of older patients, those with long term conditions and mental health conditions and vulnerable patients. They offered home visits and extended appointments for those with enhanced needs, for example during the flu season they delivered flu vaccinations to patients in their own homes if they were not able to attend the practice and they offered Saturday morning flu vaccination clinics for the convenience of working patients. They also provided their own daily phlebotomy and electro cardiograph (ECG) clinics which improved access for their elderly patients.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. They were encouraged to bring carers with them to these reviews. The practice had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. The practice cared for older patients well. Patients received annual health checks and had care plans in place.

The practice had a patient participation group (PPG). We spoke to the deputy chair of the group who told us that the practice worked well with the PPG and responded to any suggestions, comments and ideas the PPG put forward.

Tackling inequity and promoting equality

The practice was situated in a purpose built health centre and provided disabled access in all areas. There were disabled car parking and accessible toilet facilities available.

The practice analysed its activity and monitored patient population groups. This enabled them to direct appropriate support and information to the different groups of patients. The practice had a majority population of English speaking patients though it could cater for other languages as it had access to translation services. They had tailored services and support around the populations needs and provided a good service to all patient population groups.

The practice routinely provided equality and diversity training for its staff.

Access to the service

The practice was open Monday to Friday 8.30am until 6.30pm with extended hours two days per week until 8.30pm. They were closed one half day per month for training and development. Information was available to patients about appointments on the practice website and in the practice information leaflet. This included who to contact for advice and appointments out of normal working hours when the practice was closed such as contact details for the out of hours service. The practice offered pre bookable, on the day appointments, appointments with the practice nurse and home visits. Appointments could be made in person, online or by phone. Full details of how to use the phone system to make appointments, cancel appointments, and access urgent appointments was given on the website and on the telephone system. Priority was given to children; babies and vulnerable patients identified as at risk due to their condition.

Appointments were tailored to meet the needs of patients, for example those with long term conditions and those with learning disabilities were given longer appointments. Home visits were made to older patients, those living in care homes and those vulnerable housebound patients.

The national GP patient survey results which told us that only 40% of patients with a preferred GP usually got to see that GP (this was lower than the local CCG average).

Patients we spoke with, comment cards and patient survey results told us patients were not satisfied with the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment system. They expressed concern around getting appointments and said there was difficulty getting through to the practice on the telephone and getting an appointment that day. The national GP patient survey told us that only 34% of patients said they found it easy to through to the practice by phone and 45% of respondents described their experience of making an appointment as good. (These results were lower than the local average). Patients also told us that they often had to wait prolonged periods for their appointment as the appointments run over their allocated times.

The practice participated in the extended hours project run by the CCG which offered extended GP appointment hours (from 8am to 8pm). The service was delivered across Warrington and shared by the GP practices involved.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance. The practice manager and clinical staff managed the complaints and they liaised with all relevant staff in dealing with the complaints on an individual basis.

We looked at the complaints log for the last 12 months and found that complaints had been dealt with and responded to appropriately. The practice took action in response to complaints to help improve the service. The practice reviewed complaints every six months to detect themes or trends.

We saw that information was available to help patients understand the complaints system in a patient leaflet and on the website. Patients we spoke with were not aware of the complaints procedure, however they told us what they would do if they needed to make a complaint and none of the patients we spoke with had ever had cause to complain.

The practice had developed an action plan to address concerns raised in the national GP patient survey last year. This included amongst others, actions to address the concerns of ease of getting through on the phone, frequency of seeing a preferred GP, experience of making an appointment. Timescales for actions to be completed and name responsible person for the actions were detailed. The practice told us one of the plans to address the issue with appointments was to review staff skill mix and to enable patients with complex needs to have longer appointments.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver a high level of medical care to the practice population, in a flexible and patient centred way to meet choice and reflect changes in political and economic conditions. Staff could articulate the practice ethos to put patients first and to provide the best care at all times.

The practice had a business plan and strategy in place for 2015/2016. This set out their aims and objectives about what they wanted to achieve in the next 12 months. The partners held regular business meetings and away days to discuss their strategy and service development.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy. Policies and procedures were dated, reviewed and appropriate. Staff were familiar with the policies and procedures and confirmed they were aware of how to access them.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead for various clinical areas such as infection control, safeguarding, palliative care, learning disability and mental health. The GPs and practice nurses also led in business areas such as Quality and Outcomes Framework (QOF), medicines management, staffing issues and GP trainers. We spoke with staff in different roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing around the national average. For 2013/14 the practice obtained 96%. We saw that QOF data was monitored and discussed between the team and actions taken to maintain or improve outcomes.

The practice undertook clinical audits which it used to monitor quality and systems to identify where action should be taken. Clinical audits were undertaken regularly by medical staff and supporting pharmacy staff. We looked at a selection of these, they were completed well; with review of actions and improvements evident.

The practice had arrangements in place for identifying and managing risks such as fire, security and general environmental health and safety risk assessments. All staff undertook regular updating in health and safety training.

The practice held regular meetings, these were documented. We looked at a sample of minutes from last year and found that business strategy, service developments, performance, quality, significant events and complaints had been discussed.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and with the practice management team. We also noted that staff had opportunities for learning and development with a full training programme, access to eLearning and development days. Staff were also encouraged to attend CCG protected learning events.

Staff felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. Staff reported an open and no-blame culture where they felt safe to report incidents and mistakes. All the staff we spoke with told us they felt they were valued and well supported. The leadership of the practice was caring and enthusiastic about the service they provided and about caring for their staff. They demonstrated they were considering the future of the practice, service provision and succession planning.

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

We looked at complaints and found they were dealt with appropriately. The practice investigated and responded to them in a timely manner, and complaints were discussed with staff to ensure staff learned from the event.

The practice had an active patient participation group (PPG). The PPG told us they had good relationships with the practice management team and all the staff. They held regular meetings at which practice staff attended and there was good information exchange. The PPG told us they were listened to by the practice and showed us evidence of working with the practice to improve services. Action plans of suggestions made by the PPG were displayed in the practice for patients to see. Information was promoted in reception to patients encouraging them to access and

Are services well-led?

Good

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

participate in the NHS 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. We saw the results of the latest tests which were very positive with the majority of patients recommending the practice to others.

The practice had gathered feedback from patients through patient surveys, friends and family test comments and complaints. For example the results of the friends and family test for February 2015 demonstrated that when asked "would you recommend this service to friends and family", 50% respondents said extremely likely or likely to recommend the practice. The results of the last survey undertaken by the practice in October 2014 showed that a majority of patients had concerns regarding booking appointments and the booking system. The practice had responded with an action plan to address the appointments issues, however this needed evaluation as there were still concerns regarding accessing appointments.

The practice gathered feedback from staff through formal and informal staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Regular informal discussions and meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff had annual appraisals to review performance and identify development needs for the coming year. Mostly they were up to date with these.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. The practice had a training and development policy and we saw that staff were up to date with all mandatory and core training. Training was monitored to ensure staff were fully trained. Staff were trained through face to face sessions, eLearning, and CCG learning and development days.

The practice had completed reviews of significant events, complaints and other incidents. The results were disseminated via email, verbally and discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training.