Fairfield 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?	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 Fairfield Surgery on 12 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups it serves.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Governance processes in place supported safe working of staff and clinicians.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Clinicians were encouraged and supported to act early, challenging best practice guidance in cases where blood test results did not fit with patients symptoms.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were also areas of practice where the provider should make improvements. The provider should:

- Have a risk assessment in place for the decision not to have a defibrillator at the practice. This would give the contact name and location of the defibrillator available at practices located in buildings either side of the practice.
- Replace carpets in consulting rooms to improve infection control measures.

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. The practice was able to demonstrate a good track record in the provision of safe services to patients. Arrangements were in place for the reporting and recording of incidents. Clear lines of accountability were evident and staff understood their role in reporting of incidents, concerns or near misses. Strong governance processes were in place that supported safe working, for example receiving, reviewing and acting on Medical Healthcare Products Regulatory Agency (MHRA) alerts.

Are services effective?

Good

The practice is rated as good for providing effective services. Treatment of patients was informed by evidence based assessment, diagnosis and care planning. Processes in place ensured that all treatment delivered had been consented to and that this was recorded. The practice was able to give several examples of recently completed clinical audit cycles. Results were used to inform and drive improvements, where possible, to the treatment and outcomes of patients. The practice was proactive in engagement with other services who were responsible for shared community care of patients, for example, those patients receiving end of life care.

Are services caring?

Good

The practice is rated as good for providing caring services. All patients we spoke with told us they were treated with dignity, respect and compassion. Patients commented that the GP/ patient relationship was very good, that they felt listened to and were given enough time within each consultation to discuss their healthcare needs.The GPs displayed a strong commitment to ensuring patients received the very best care and support at end of life. The lead GP gave carers or family members a mobile number to use, if the care of a patient fell short of what was planned or expected.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We met with members of the Patient Participant Group (PPG) on the day of our inspection. The practice was able to show us results for the Friends and Family Test, for the months of January, February and March of 2015. These showed that for each month, over 90% of patients seen would recommend the practice to a friend or family member. Further analysis showed that the 90% of patients that responded were either likely or highly likely to recommend the practice. Other responses were marked as neither likely nor unlikely

Summary of findings

to recommend. Annual patient surveys had been carried out in 2012, 2013, 2014, and 2015. On analysis of each surveys results, an action plan had been drawn up, with the involvement of the PPG, to address any areas that required improvement. The practice was able to demonstrate its commitment to acting on patient feedback.

Are services well-led?

Good

The practice is rated as good for providing well-led services. Leaders were accessible to all staff, and were appreciative of the role all staff played in the delivery of high quality care and treatment services to patients. Staff told us they felt valued by management and felt proud to work at the practice. Governance arrangements supported the daily work of the practice team, outlining clear areas of responsibility for all staff. All staff had received training appropriate to their role and were given opportunities for further development.

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 kept a register of those patients aged over 75 years, who required additional support, and for those who were deemed as vulnerable to unplanned hospital admission. The practice had a safeguarding policy in place in respect of vulnerable adults, and staff when referring to this, included older people who could be vulnerable to abuse. We were able to speak with a patient from this population group, who told us clinicians always involved them in decisions about their care and treatment. The patient told us that the nurse and GPs always asked for their consent before examining them or delivering any treatment, for example, annual flu vaccines.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions.

The practice nurse led disease management clinics for those patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes and asthma. Any unplanned admissions of patients with long term conditions were reviewed by the nurse and GPs to look for any triggers and whether anything could have been done to prevent this. Patient care was well planned. For example we saw how patients were systematically called in to replace or receive emergency treatment packs, containing antibiotics and other medicines that could prevent hospital admission if taken immediately. The nurse also delivered cytology screening services and helped patients who had changing dietary needs, for example, those with gluten intolerance.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Patients who had young children told us access to the service was good. Children who used the service could see a GP on the same day if this was required. All staff and clinicians were aware of the practice safeguarding policy in relation to children and could refer to this when asked how they would raise any concerns. We saw information on safeguarding and who to contact and report to, was displayed prominently at the practice. Systems in place ensured that children who required vaccination and immunisation against childhood illnesses were given appointments. Any failure to attend appointments was reported to the area team who would follow this

Summary of findings

up. Clinicians we spoke with displayed knowledge of Gillick competency and spoke about how they consulted with younger patients in an age appropriate way. Child development clinics were tied in with post natal appointments and six week checks of new born children, to increase the effectiveness of each visit to the practice.

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 had a range of services to meet the needs of patients from this population group. We saw that referral rates to, and success in smoking cessation was good. The practice kept data to enable them to gauge the effectiveness of the treatment pathways used for smoking cessation. The practice provided health checks to those patients aged between 40 and 74 years old, which allowed opportunistic interventions to offer help and support with weight management and early detection of other conditions that are more prevalent with age, for example, diabetes and dementia.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of those people whose circumstances may make them vulnerable.

The practice kept registers of patients who were more vulnerable, for example those with a learning disability, to ensure that these patients received regular health checks and to ensure that if information needed to be shared, for example, with a carer, this was recorded appropriately. The practice worked with the local learning disability specialist nurse, to deliver health awareness sessions at the practice, and to offer practical advice and support to carers. The practice supports a women's refuge in the area. Staff worked to ensure that patients from the refuge were offered an appointment immediately, and that the needs of any children were also met quickly. The practice was recently audited by an advocacy group for patients who were deaf, achieving high scores for its services to deaf patients and how they were supported by the practice.

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 those with dementia).

The practice held a register of those patients being treated for a mental health condition, and for those with a diagnosis of dementia. These patients received regular health checks to ensure their

Summary of findings

physical health needs were addressed. The practice had been involved in the dementia screening programme which ran throughout 2014, and offered screening and referral to a memory clinic for any patient who had experienced memory loss.

Summary of findings

What people who use the service say

We received 45 Care Quality Commission (CQC) comment cards, which patients had used to express their views on the service. Of these, 42 contained positive comments relating to the service, access to GPs and the practice nurse, and the friendliness of reception staff. Three cards described areas of dissatisfaction, such as not being able to get through to the practice by phone at peak periods during the day. The practice manager explained that they had increased the working hours of reception staff and now had three incoming lines for patients to call. However, it was acknowledged that peak periods could make it difficult for patients to get through to the practice and services were reviewed regularly to help meet demand.

The practice had commissioned patient surveys annually since 2012, and had published results and findings on its website. Each year, the practice had developed an action plan, with input from the practice Patient Participant Group (PPG), in response to findings from the survey. In the 2015 survey, patients had responded in significant numbers, saying that the waiting time at the surgery when arriving for an appointment could be up to 30 minutes. The practice had responded to this, explaining the length of appointments and how the impact of patients needing more time with a GP, could snowball throughout the morning or afternoon. As a result of this, reception staff now advise patients arriving for appointments, if the doctors or nurse are running late, and how long a patient's wait may be.

In the last NHS England GP Patient Survey, the practice scored very highly in areas that are known to be particularly important to patients. The scores of the practice in many cases were higher than the England average, and higher than the average scores of neighbouring practices. For example, 91.6% of patients reported that their GP was good at giving them enough time to discuss their health concerns. Locally, practices scored 86.4% and nationally, 85.3%. When patients from the practice were asked, 86.1% of patients said their GP was good at explaining test results and treatments to them. This compares to a score of 83.4% of patients locally, and 82% of patients nationally. When patients were asked how good their GP was at treating them with care and respect, 90.1% of patients responded positively. The England average score for this question was just 82.7%, and locally, other practices scored just 84.5%.

Areas for improvement

Action the service SHOULD take to improve

- Have a risk assessment in place for the decision not to have a defibrillator at the practice. This would give the contact name and location of the defibrillator available at practices located in buildings either side of the practice.
- Replace carpets in consulting rooms to improve infection control measures.

Fairfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The inspector was accompanied by a specialist GP Advisor.

Background to Fairfield Surgery

Fairfield Surgery is located in Warrington, Cheshire. The practice building is laid out on two floors. The ground floor has two consulting rooms, one treatment room, a reception office area, patient waiting area, and disabled toilet facilities with baby changing room. The upper floor is laid out to provide office space for the practice manager, records storage, staff area, bathroom and a meeting room. There is a basement area which is used to store archived paper patient records.

The practice is a partnership of three GPs, two female and one male. The patient register is made up of almost 3,000 patients. The practice is open from 8.00am to 6.00pm Monday to Friday. Some extended hours provision is offered on Tuesday evening until 6.30pm and on Wednesday morning from 7.30am. The practice can offer minor surgical procedures at the practice, for example joint injections. The practice nurse offers disease management clinics for those patients with long term conditions such as diabetes, asthma and other respiratory illnesses. All baby and childhood vaccinations and immunisations are offered by the practice, as well as a number of screening services, for example cytology screening. Regular health checks for specific patient groups are available, along with health care advice and guidance on smoking cessation, weight management and contraceptive advice. Contraceptive implants are not provided by the practice, but patients are referred to a neighbouring facility were this service can be delivered.

Services are delivered under a Personal Medical Services (PMS) contract. The practice does not provide out of hours services. These are provided by Bridgewater Health Care, who are contracted by Warrington Clinical Commissioning Group.

Our inspection was carried out on 12 May 2015. A new partner had been appointed at the practice from 1 April 2015. However, CQC had not received an application to add the partner to the registration of the practice. It is a legal requirement that the practice informs CQC of any changes to the partnership. The practice manager and lead partner confirmed that the appropriate paperwork was almost completed and would be submitted immediately.

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.

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:

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 May 2015. During our visit we spoke with a range of staff including two GP partners, the practice manager and administrative support staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice is rated as good for providing safe care and treatment. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and Medicines and Healthcare Products Regulatory Alerts (MHRA). Staff were clear on how to deal with comments and complaints received from patients. Staff were aware of their responsibility to raise concerns and knew how to report incidents and near misses.

Staff were encouraged to report any safety incidents and these were discussed at weekly practice meetings. Minutes kept of these meetings confirmed this information.

The practice manager was knowledgeable on what should be reported, to whom and what follow-up action was required. The practice manager could demonstrate that they had access to on-line materials which could be used for guidance and training on this. Information from NHS England showed that the practice had a good track record in respect of patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events was a standing item on the practice meeting agenda and minutes of those meetings confirmed that there was an open, transparent and supportive culture in place, to encourage staff and clinicians to record and report significant events. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. When appropriate, the practice shared findings from significant events more widely. In one example we saw how other GP practices, attached to the practice as part of a federation, shared knowledge to promote better patient outcomes and patient safety. In an example we reviewed, we saw how the practice communicated with any patients concerned about their findings, and explained to those patients what could be done to prevent such circumstances arising again in future.

Staff, including receptionists, administrators and the practice nurse knew how to raise an issue for consideration at practice meetings and they told us they felt encouraged and safe to do so.

Reliable safety systems and processes including safeguarding

The practice had systems in place to receive, read and discuss any safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). These were circulated and printed by the practice manager. All clinicians were required to record that these had been received and read. As two of the practice partners worked on a part time basis, the GPs and the practice nurse, met at the end of morning surgery for huddle meetings to discuss particular patients, safety alerts or for any follow up on findings from significant event analysis. The practice could demonstrate that systems in place promoted effective communication between staff and helped keep patients safe. A day book in the reception area was used by members of staff to record and hand over messages if they were not going to be available the following day.

The practice had a safeguarding policy in place, which staff where able to refer to. We saw that all staff were aware of who the safeguarding lead was for the practice, and who the deputy was. The practice kept a safeguarding file, accessible to all staff, in paper and electronic form. This included flow charts which set out who staff should contact to raise a safeguarding alert. We saw that electronic patient summary records were visible to out of hours services and that the practice kept a register of safeguarded patients which was updated as required and faxed to the out of hours provider at the end of the working day.

GPs and the practice nurse had all been trained to the required level (Level 3) in safeguarding of children and vulnerable adults. Non clinical staff had also received safeguarding training and regular refreshing of this through on-line resources. When we spoke with reception and support staff, they were able to clearly describe evidence of different types of abuse that they should be vigilant for, particularly in vulnerable adults, such as self- neglect, unkempt appearance, anxiety and unexplained bruising or injury. The GPs we spoke with told us the practice list was still of a size to allow staff a good knowledge of patients, but GPs reminded staff to be vigilant and to question patients in a caring manner if they had any doubts about patient safety.

Good

Are services safe?

The practice had a chaperone policy in place. This was displayed in each consulting and treatment room and in the patient waiting area. All staff had been subject to enhanced background checks through the Disclosure and Barring Service (DBS) to check they were suitable to deliver these duties. Staff had received chaperone training and could clearly describe how they would deliver these duties and how the GP or nurse would record that they had acted as a chaperone, in the consultation record.

Medicines management

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The area Child Health Team took the lead on delivery of childhood vaccinations and immunisations. Where children missed pre-set appointments for this, the practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the practice nurse had received appropriate training to administer vaccines. The practice nurse managed the medicines fridge at the practice ensuring all medicines were kept safely, within the correct temperature range and in date order. The practice had a cold chain policy and all staff were aware of the protocols around delivery, receipt and storage of medicines. Temperature checks were kept for the medicines fridge and arrangements were in place to deal with any mechanical failure of the vaccines fridge.

The practice had responded to data which had shown them to be higher prescribers of certain medicines, for example the prescribing of certain antibiotics. Audit showed that this was due to repeat prescribing for weekly courses of antibiotics, which followed guidance issued by a urologist. There were also instances of prescribing antibiotics in line with current guidance for treatment of prostrate related illness, which extended to a period of six months. The practice was also able to point to links between antibiotic prescribing for 'rescue packs', and lower unplanned hospital admissions than the England average, for conditions such as chronic obstructive pulmonary disease (COPD). Rescue packs contain medicines including antibiotics, to be used if a patient's symptoms become much worse, usually during winter months. We asked the lead GP about the higher instance in prescribing of some hypnotic medicines. Data showed that the practice value for this was 0.49, compared to an England average of 0.28. The practice GPs were able to show this was in relation to patients with acute back problems. From our inspection we found that all GPs were conscious of their prescribing and that prescribing was discussed as a regular agenda item at practice meetings. The practice also worked with the local clinical commissioning group (CCG) to ensure local guidance and updates on prescribing were followed.

Cleanliness and infection control

The practice had undertaken an infection control audit, conducted by the infection control lead from the local CCG. The practice had achieved a score of 98% for the audit, which took place in June 2014. Areas where improvement was needed were identified as the environment, which still had carpeted consulting rooms, and in hand hygiene as the practice does not have sinks fitted with elbow lever operated taps. The practice manager told us there were no immediate plans in place to refit consulting rooms, but this was something they were aware of and would make the necessary changes when finances allowed.

The practice manager took the lead on infection prevention control. We saw that measures were in place to ensure that all parts of the practice were clean, tidy and suitable for use. Cleaning schedules were in place for the appointed cleaner/housekeeper to follow. Details of products to be used and instructions for this were also available. Regular audits conducted by the practice manager on a weekly and monthly basis, were in place to ensure infection control standards were maintained.

When we conducted a visual inspection of the building, we saw that all areas of the practice were very clean, tidy and that consulting rooms were free of clutter. The treatment room at the practice was small, but safely maintained. A review of items kept in the room was required, to minimize space taken up by supplies. Any samples brought to the practice by patients could be dropped into a sealed box, which was collected daily by a courier. Spill kits to deal with any spillage of bodily fluids were available in treatment rooms and within the reception area. Staff had been trained in the use of these and understood the importance of using personal protective equipment when dealing with any spillage. All consulting and treatment rooms were checked by the practice manager daily to ensure stocks of equipment and cleaning standards were maintained.

Good

Are services safe?

Single use items used by the practice GPs and nurse for example syringes, were disposed of safely and contracts were in place to have clinical waste removed from the practice.

The practice did not routinely conduct annual legionella testing to check for the presence of this bacteria. Exposure to this bacteria can be extremely harmful and steps should be taken to assess the risk of exposure to patients. The practice had taken advice from the Health and Safety Executive, in conducting a risk assessment on the practice premises and its water supply. Results of the risk assessment showed the practice to be at very low risk of harbouring this bacteria. As a precaution staff flushed all toilets and turned on all taps to let them run for at least 30 seconds each morning to clear any water that had been standing for a period of time, i.e. overnight or over weekends.

We noted from an audit conducted on surgical procedures carried out at the practice, that in a twelve month period, 115 procedures were performed. There had been no instance of complication by way of wound infection, experienced by any of the patients.

Equipment

The practice manager kept a register of all equipment at the practice. This was used to plan servicing and maintenance in a timely manner. When we checked equipment, we saw this was clean, well maintained and suitable for use. Records showed that all equipment used for measurement, such as blood pressure cuffs and weighing scales had been recently tested and calibrated to ensure accuracy. The practice was able to demonstrate that contingency arrangements in place were sufficient should any piece of equipment be found to be unsuitable for use. All portable electrical appliances had been tested in March 2015 and contracts were in place for re-testing annually. Emergency lighting facilities, fire alarm and security measures were tested every six months. Fire extinguishers and door seals were last tested in October 2015 and were re-tested annually. All fire extinguishers were recharged every five years as standard. The oxygen cylinder for use in emergency was checked and maintained by an external contractor, to ensure it safety and suitability for use.

Staffing and recruitment

The practice had a recruitment policy in place. We checked several staff files to see if the staff recruitment policy was effective and whether it was followed in practice.

In the file of the most recently recruited member of staff, we saw detailed notes from interview and of previous employment history had been taken and that this was checked. Two primary forms of identification were kept on file, for example a copy of a passport, taken by the practice manager, and a birth certificate. Proof of address was also taken by way of utility bill. All staff files we checked contained two references from previous employers or from a previous employer which was supported by a character reference. Copies of qualifications and confirmation of up to date registration with a relevant professional body were held, for example in the case of the newly recruited GP, their General Medical Council (GMC) registration. Copies of medical insurance cover were also on file. We saw that evidence of enhanced background checks for all staff were held by the practice manager. The lead GP and new practice partner had been revalidated in 2014. The revalidation of the other partner was due in January 2016

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety lead for the practice.

We saw that any risks were discussed at practice meetings and steps to reduce risk were recorded and shared. The practice manager kept a risk management file and as part of the practice governance processes, checked this regularly to see if any risk assessments required updating. For example, the practice was in the process of converting land at the back of the practice to a car park. Fire risk assessments and evacuation procedures were revisited to check what changes may need to be made to evacuation procedures and assembly points.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place which meant they could respond and act quickly in the event of an emergency or major incident. For example, in the case of

Good

Are services safe?

damage to the practice by extreme weather, or in the event that staff would be unable to attend work. The practice was part of a federation of practices, one of which was located in the building next door. A buddy arrangement for extra desk space, staff cover and access to clinical items was in place, with support offered by other practices within the federation. This was detailed in the disaster recovery plan which was held by key staff members at their home address as well as at the practice.

In the event of a medical emergency, all staff had been trained in cardio-pulmonary resuscitation, (CPR) and first aid. We saw this training was refreshed annually. The practice did not have a defibrillator available for use in an emergency. We were told that the practice had access to this piece of equipment, which was held by the practice in the adjoining building. However, the provider had not conducted a risk assessment on how the decision had been reached not to have a defibrillator of their own, or which gave the details of access and precise location of the equipment in the adjoining building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Each newly registered patient with the practice was offered a full health check. Patients' needs were assessed and a comprehensive review of their medicines was conducted. Where necessary, patients were added to registers to ensure that their condition was regularly monitored by the practice nurse and GPs.

The practice had conducted reviews of the patient register to identify patients aged 75 years and over, as well as those vulnerable to unplanned hospital admission. Each of these patients had been seen by the GP and had their needs assessed. A care plan was in place that focussed on health care designed to reduce the risk of unplanned hospital admission.

The practice had a lower number of unplanned admissions per thousand patients, than the average figure for England. Figures available showed the rate of emergency admissions of patients with care sensitive conditions (for example, respiratory illnesses) to be 10.11 patients per thousand, as opposed to 13.6 per thousand patients, which was the England average. When we asked about this, the lead GP attributed this to the areas of specialist interest of the partners at the practice. For example the area of specialist interest of the lead partner was diabetes and cardiology. Data available to us showed that patients with long term conditions, such as heart problems and diabetes were well managed supported. For example, the percentage of patients with atrial fibrillation, (a heart condition) measured within the last 12 months, who were currently being treated according to NICE guidance was 100%. Similarly the percentage of patients with diabetes on the practice register, for whom the last blood pressure reading fell within ranges accepted by NICE as safe, was 92.06%. The national score for this patient outcome is 78.55%. Both these statistics demonstrate that patients with long term conditions, were being effectively assessed, considering NICE guidance.

Management, monitoring and improving outcomes for people

The GP partners we spoke with clearly explained their approaches to treatment, and references to care and treatment pathways. They were familiar with best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and discussed. The GPs shared an example that demonstrated how patients' needs were reviewed and assessed in line with updated guidance, and how monitoring patients through clinical audit had improved patient outcomes.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits we reviewed included an audit of patients and their asthma medication, an audit of patients who had minor surgery at the practice, a cancer audit and an audit on safeguarding standards at the practice. Any learning from audits was documented and shared at practice meetings. Where possible, findings were shared at cluster group meetings of practices in the area, and within the federation the practice was part of. For example, from the safeguarding standards audit, clinicians and staff reviewed the correct read coding allocated to patients on their computer system to ensure those used were correct and as recommended by the Royal College of General Practice/NSPCC Safeguarding Children and Young People Toolkit.

The practice had an action plan in place to target areas of patient liaison that could be improved. These areas were selected from data produced by an Information Governance toolkit used by the practice manager. The improvements focused on asking questions of patients in the practice annual survey about how they thought their information was used and protected and about reassurance to patients on this subject.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with mandatory training courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. The practice manager had training plans in place that meant even though the administrative support team was relatively

Good

Are services effective?

(for example, treatment is effective)

small staff had sufficient skills and experience to ensure all duties could be covered. We saw that there were enough qualified and experienced staff in place to deliver services safely and effectively.

The practice partnership was made up of two part time female GPs and one full time male GP. The combined sessions of the GPs totalled just over two full time equivalent GPs. Review of demand for patient appointments showed the mix of skills and gender of GPs was sufficient to meet patient requirements. The practice nurse (female) delivered patient led clinics for the management of long term conditions, catch-up clinics for childhood vaccines and immunisations, new patient appointments, cytology screening and opportunistic health education and support, for example, referral to smoking cessation services. The practice nurse provided 10 hours each week for patient care. Review of patient demand by the practice manager showed that this was sufficient to meet the needs of patients.

Working with colleagues and other services

The practice worked with other service providers to ensure that all patient information was recorded accurately and quickly, for example, blood test results, X ray results, discharge summaries and feedback from out-of-hours GP services. Staff could confidently explain the system in place that ensured the GPs and nurse had sight of these results and communications, and how any follow up action would be initiated.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those receiving end of life care. The practice followed a recognised care pathway for terminally ill patients and met with community clinicians every three months to discuss their care and support. The practice reported that it had a good working relationship with the out of hours service and confirmed that it shared updates on palliative care patients with the out of hours provider. We noted that in many cases the lead partner at the practice gave their mobile number to carers of those patients at end of life, to ensure they received the support they needed.

The practice reported that it had a low rate of attendance of children at the local accident and emergency unit. The GP partners attributed this to its policy of seeing any unwell child on the day. If unable to see any child patients, the practice referred children to the services of a paediatric clinic located nearby, who could offer appointments on that day.

Information sharing

The practice manager was able to show us how records of patients who were subject to a safeguarding plan were highlighted. We asked how the out of hours service would be able to see this information as it was unclear how much of the patient record they could access. The practice manager confirmed that any records of patients subject to a safeguarding plan, had this recorded in the patient summary sheet, which was confirmed as being viewable by out of hours practitioners.

We looked at systems in place at the practice to support timely information sharing between hospitals and the practice. Staff were confident on how incoming correspondence, in electronic or paper form, should be actioned. We saw that requests for patients' notes were dealt with each day, so no patients' treatment would be delayed. Links in place on the practice computer to patient referrals, ensured copies of recent blood test results, x-rays or scans were also sent with any patient referral. The effective and efficient management of the administrative work of the practice contributed to patient safety and effective referral between care providers.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Act 1989 and 2004 and their duties in meeting the requirements of this legislation. Staff we spoke with understood the key parts of the legislation and were able to describe how they implemented this in their daily practice.

We saw from records that the GP partners and the practice nurse were up to date with training on the Mental Capacity Act 2005, The Children's Act 1989 and 2004 and Gillick competency. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The GPs we spoke with were able to demonstrate their understanding of this. The lead GP told us that when clinicians at the practice were examining patients from different ethnic backgrounds, they accepted implied consent but that GPs were advised to seek confirmed (written) consent. In doing this the practice wished to avoid any misinterpretation of patients' wishes.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

All patients registering with the practice were offered a full health check with the nurse or GP. Those patients diagnosed with long term conditions were added to the appropriate register to ensure they received timely reviews of their health and medications. The nurse held clinics to review patients receiving hormone replacement therapy (HRT). These interventions were used positively by the nurse to encourage women to carry out regular breast checks. All patients with respiratory conditions were seen regularly by the nurse and issued with 'rescue packs'. These were made up of emergency medicines for use in the event of an exacerbation of the patient's condition, for example a course of antibiotics and medicines administered by inhalers.

The practice had performed well in the referral of patients to smoking cessation support services. Figures from the practice showed that, of those who attended the support services, 50% had achieved a non-smoking status 12 months from cessation.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 45 Care Quality Commission (CQC) comment cards, which patients had used to express their views on the service. Of these, 43 contained positive comments relating to the service. Patients commented on the high levels of involvement they experienced when discussing their care and treatment, saying that GPs, the practice nurse and staff treated them with kindness, dignity and respect. The lead partner GP told us how the practice GPs sought to give those patients with a diagnosis of terminal illness, a sense of security regarding ownership of their treatment. At the first consultation following diagnosis, GPs told us they reassured patients that treatment would help manage their condition, meet their needs and that GPs would be responsive to their concerns. The GPs displayed a strong commitment to ensuring these patients received the very best care and support at end of life. The lead GP gave carers or family members a mobile number to use, if the care of a patient fell short of what was planned or expected.

In the last NHS England GP Patient Survey, results published in January 2015 showed the practice scored very highly in areas that are known to be particularly important to patients. The scores of the practice in many cases were higher than the England average, and higher than the average scores of neighbouring practices. For example, when patients were asked how good their GP was at treating them with care and respect, 90.1% of patients responded positively. The England average score for this question was just 82.7%, and locally, other practices scored just 84.5%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them 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. The practice kept details of patients' carers, so that they could be informed and involved as required, whilst observing protocols around patient privacy.

The practice had recently been audited by an external advocacy service for patients who were deaf. The practice scored very highly for involvement of these patients in how their treatment could be delivered and in using appropriate communication tools to ensure patients understanding of options available to them. The practice had arrangements in place to book an interpreter who used British Sign Language should a patient need this. Advice had been provided by the advocacy service on how to best use a portable and fixed hearing loop at the practice. This was an item that had been included for consideration on this year's budget for the practice.

Patient/carer support to cope emotionally with care and treatment

Practice staff were knowledgeable on support services locally that could be accessed by patients and their carer's. Notice boards and leaflets in the waiting and reception areas gave details of services available to patients. These were regularly reviewed to check the information and contact information given was correct.

The practice kept a register of those patients who were also carers. These patients were offered longer appointments if required and received regular annual health checks to ensure their own physical health was not overlooked.

We spoke with patients who were also parents of very young children. Parents told us that GP support for them as parents of sick children was excellent. They told us the GP and practice staff gave them as much information about their children's condition as possible, and that this helped them feel informed and more able to manage their child's care and treatment regime.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an active Patient Participant Group (PPG). We met with three group members as part of our inspection. They told us that the practice manager, GPs and nurse responded positively to their suggestions. For example, when putting together questions that would make up the annual survey for the practice, the PPG gave areas of focus, which could be concentrated on in each survey. The PPG shared ideas on the production of a newsletter which would be posted on the practice website and could also be made available to patients in paper form at the practice. The newsletter would give details of established and new community support organisations, as well as any seasonal health initiatives. We found the PPG to be enthusiastic in their support of the practice. We did note that there was no facility on the website or at the practice, to display the names of members of the PPG, should a patient wish to speak to them directly.

Tackling inequity and promoting equality

The practice provided services to a local women's refuge. Systems in place at the practice followed best practice guidance, in that patients were registered as permanent rather than temporary patients, and records were requested from the previous practice patients had used. In doing this, the practice ensured it could correctly and quickly identify any vulnerable adults and children who were subject to safeguarding plans.

The practice kept registers of those patients who required more regular health check-ups, for example, patients with a learning disability. The practice liaised and worked with the CCG specialist learning disabilities nurse, to ensure that health promotion initiatives reached these patients and that they achieved full access to all healthcare.

The practice had been audited by an advocacy service for deaf people, "Life and Deaf Matters". The practice had scored well in this, demonstrating that it provided a range of communication tools for patients who were profoundly deaf. Patients were given extended appointment times and if responses to requests to attend appointments were not replied to, staff would follow this up to ensure the request had been received and understood. Staff also ensured that patients could attend with their carers or advocate, and that the patient was happy to be with their carer or advocate during consultations.

Access to the service

The practice opening hours were from 8.00am to 6.30pm, Monday to Friday. The lead GP was available throughout the week, delivering nine sessions, between Monday and Friday. The lead partner was supported by two partners who worked part time. The combined working hours of the GPs was equivalent to two full time GPs. Some extended hours provision was offered on Tuesday evening until 6.30pm and on Wednesday morning from 7.30am. We could see from data the practice manager shared with us that appointment availability met demand. We also noted the rate of failure to attend appointments was extremely low, at approximately 2% per week.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Home visits were available where needed and GP's were flexible on how many telephone consultations they could provide at the end of morning surgery. Typically each GP would provide four telephone consultations each day.

The practice met the requirements of the Equality Act 2010, in that the practice was fully accessible to wheelchair users and those people with limited mobility. The practice staff could request interpreter services via the Language Line facility. The practice had identified that patients who were originally from Poland were the largest group of patients who did not speak English as a first language, and could produce information in Polish if patients required this. The practice had a small number of deaf patients; systems were in place to engage an interpreter who used British Sign Language if required, and for communications to be sent by fax when necessary. The practice manager was able to show us research they had done on the purchase of either a fixed or portable hearing loop for the practice. This item was entered on the purchase agenda for this financial year.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We reviewed complaints the practice had received in the past three years. We saw that the practice applied the same level of investigation and analysis as it did to significant events. This meant that conclusions were drawn from investigations into complaints. We saw a particularly good example of this, in the handling of a complaint about a GP not visiting a patient at home. Investigations showed that a patient remained in pain due to failure to correctly diagnose the patients symptoms following referral for an x-ray. The practice could link this incident to two others which had been treated as significant events. Information revealed in patient x-rays had not been correctly interpreted and relayed to patients. As a result details of all three incidents were sent to the local hospital trust in order that any training in use of a portable x-ray machine was re-visited. The practice also pointed to the possibility that the service that reviewed x-rays was not correctly or accurately interpreting x-ray results. The practice also shared the findings of this complaint investigation more widely, with the federation of practices it was part of, and practice clusters within Warrington Clinical Commissioning Group. The practice shared findings with patients and were appropriate offered an apology to patients concerned.

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 of how it should seek to provide services to patients. The staff and clinicians spoke of their commitment to delivering high quality care and to promoting good outcomes for patients. The partners particularly spoke of their work with patients who had received a diagnosis of terminal illness. Their commitment to the patient was to give a sense of security regarding ownership of their treatment. In this, the GPs sought to reassure patients about the standard of care they would receive and introduce the patient to key team members within the community that would support patients and the carers along the palliative care pathway. The practice GPs, nurse and all support staff shared the values of the practice and the commitment to providing joined up care and treatment that met patients' needs.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff at any time from induction through to annual refresh training. Policies could be accessed on the shared of the practice computer system and in paper form. We could see from comprehensive staff records all staff had completed refresher training on these. When we reviewed staff records we found all staff had received a copy of their job description explaining their role and responsibilities. We saw that there was a clear reporting structure for staff to follow. Regular performance reviews for staff were in place and all staff had received annual appraisals.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and to identify where action should be taken to make improvements. Audits completed in the past 12 months included an audit of safeguarding processes at the practice for vulnerable adults and children. The audit showed that all systems in place worked well and that safeguarding leads were confident in their responsibility to record, report and action any safeguarding referrals.

Leadership, openness and transparency

Staff told us leaders were accessible and approachable. We saw the practice held regular practice meetings were all staff were kept up to date on operational and performance matters. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Staff commented that relationships were supportive and encouraging and told us they felt valued and appreciated by their leaders.

The practice had a whistle blowing policy in place. Staff we spoke with understood what the term whistle blowing meant and could refer to the policy and describe actions they would take if they felt the need to act as a whistle blower.

We saw from investigations into complaints, significant events and in peer review of the GPs and practice nurse's work that leaders were open and transparent. This promoted a culture of learning in the practice. The lead partner told us how he encouraged GPs and the nurse to be 'naturally curious' if patient symptoms did not fit with test results.

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

The practice commissioned an annual patient survey to gather feedback from patients. We saw that the results for this had been collated and discussed with the Patient Participation Group (PPG). An action plan for focussing on specific areas had been drawn up and shared with the PPG. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. When we spoke to patients and staff, we found all were confident in approaching the partners with any concerns, describing an 'open door' culture, were leaders took time to talk through any areas of concern and investigate were appropriate to do so.

The practice had a very low staff turnover. The lead GP put this down to the level of inclusion of staff and of the reputation of the practice for open communication with patients, recognising the level of trust patients had in the leaders of the practice.

Are services well-led?

Good

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

Management lead through learning and improvement

The lead partner told us how he encouraged GPs and the nurse to be 'naturally curious' if patient's symptoms did not fit with test results. We were shown one example of patient care reviewed by the GPs, where a patient had presented with symptoms of arthritis, but went on to have other illnesses diagnosed due to the GP employing a more curious approach. As a result of early diagnosis of other illnesses, treatment was started quickly, benefiting the patient.

The practice had joined with five other practices to form a federation. GP partners told us the practice had benefitted from this, learning from the larger practices who shared information and expertise on management of services. The practice also spoke of plans that would allow the commissioning of a greater number of services for patients, which enhanced and maintained the skill levels of the practice GP's and nurse.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us the practice was very supportive of training opportunities and encouraged staff to attend events for training beyond what was considered as mandatory training.