South Park Surgery

Quality Report

South Park Surgery, Waters Green Medical Centre
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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

This is the report of findings from our inspection of South Park Surgery. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 2 December 2014 at the practice location in the Waters Green Medical Centre, Macclesfield. We spoke with patients, relatives, staff and the practice management team.

The practice was rated as Good. They provided safe, effective, responsive and compassionate care that was well led and addressed the needs of the diverse population it served.

Our key findings were as follows:

- The practice had a good track record for maintaining patient safety. Effective systems were in place to ensure patients were safe from risks and harm. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Staff were safely recruited. Infection risks and medicines were managed safely.
- Patients spoke highly of the practice. They were very pleased with the individualised care given by all staff. They told us staff were kind and caring and treated them with dignity and respect.
- The practice provided good care to its population taking into account their health and socio economic needs. Patients were listened to and feedback was acted upon. Complaints were managed appropriately.
- People's needs were assessed and care was planned and delivered in line with current legislation and guidance.
- The practice monitored, evaluated and improved services. They worked in collaboration with the CCG and NHS England. Staff enjoyed working for the practice and felt well supported and valued.

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

The provider should:

- Ensure telephone access to the surgery and appointments is improved.

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.

Information and data from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. Effective systems were in place to provide oversight of the safety of patients. Incidents and significant events were identified, investigated and reported. Lessons learnt were disseminated to staff. Child and adult safeguarding was well managed. Staff were trained and supported by a knowledgeable and proactive safeguarding lead. The practice was proactive in identifying, supporting and sharing information in order to safeguard patients and when appropriate, made safeguarding referrals.

Are services effective?

Good

The practice is rated as good for providing effective services.

National and local data showed patient outcomes were average or above average for the locality. The National Institute for Health and Care Excellence (NICE) guidance was accessible, discussed, referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation and guidance. This included assessment of capacity and health promotion. Staff were well trained appropriately to their roles and further training needs had been identified. The practice carried out appraisals and personal development plans were in place for all staff. Multidisciplinary team working was evident.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of their local population. They engaged with other local practices and the local Clinical

Summary of findings

Commissioning Group (CCG) to secure service improvements where these were identified. The practice had identified the need to improve access to the appointments system and the telephone system. Complaints were responded to appropriately and there was an accessible complaints policy and procedure.

Are services well-led?

Good

The practice is rated as good for being well-led.

Staff were clear about the practice values and vision and their responsibilities in relation to these. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Regular team meetings were held. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection and we received 27 completed CQC comment cards. Patients whom we spoke with varied in age and population group. They included older people, those with long term conditions, those of working age and those with a mental health condition.

All patients were very positive about the practice, the staff and the service they received.

They told us staff were helpful, caring and compassionate, they were treated with dignity and respect and had confidence in the staff and the GPs who cared for and treated them.

The main concern from speaking to patients, comment cards received on the day and from the patient survey was appointments. Patients told us the main complaint was that it was difficult to get through on the telephone, appointments were sometimes difficult to get and they sometimes had delays in waiting times to see the GP.

Only 37% of patients responding to the NHS GP patient survey said it was easy to get through to the surgery by phone. Fifty two percent described their experience of making an appointment as good.

The results of the national GP patient survey published in July 2014 told us that 80% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, 74% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 70% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. Ninety percent said they last GP they spoke to or saw was good at listening to them, whilst 81% said the GP was good at explaining treatment and tests and 93% had confidence and trust in the GP.

Patients told us staff gave them time, listened to them and nothing was too much trouble. They said they were treated as individuals Doctors were very professional and caring. Patients told us the environment was clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve

- Ensure telephone access to the surgery and appointment system is improved.

South Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP and a specialist advisor who was a Practice Manager:

Background to South Park Surgery

South Park Surgery is registered with the Care Quality Commission to provide primary care services. It provides GP services for approximately 12,500 patients living in and around Macclesfield. The practice has four GP partners, three salaried GPs, a practice manager, practice nurses, healthcare assistants and administration and reception staff. The practice is also a GP training practice, offering support and experience to trainee doctors.

The practice is open Monday to Friday from 8.00am to 6.30pm. They are closed one half day eight times per year for training and development. Patients can book appointments in person, online or via the telephone. 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 medical services.

The practice is part of East Cheshire Clinical Commissioning Group (CCG). The practice is situated in an affluent area with low deprivation. The practice population is made up of a slightly higher than national average older population and a lower than national average of patients aged under 40 years. Fifty seven percent of the patient population has a long standing health condition and there is a lower than national average number of unemployed.

The practice does not deliver out-of-hours services. These are delivered by East Cheshire NHS Trust who provides a service locally in Macclesfield.

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:

- 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)

Detailed findings

- 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 manager, registered manager, GP partners, a GP registrar, practice nurse, administrative staff 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 ringing the practice. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We also talked with family members of patients visiting the practice at the time of our inspection.

Good

Are services safe?

Our findings

Safe track record

Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards (GPOS) showed no concerns. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development. These were submitted to the CCG via an electronic reporting system. We looked at some recent significant events from 2014 which had been analysed, reported and discussed with relevant staff.

The practice had systems in place to monitor patient safety. The practice manager, GPs and any other relevant or involved staff investigated and reported the significant events. Documented evidence confirmed that incidents were appropriately reported. Action was taken to learn lessons and put measures in place to reduce the risk of the event recurring in the future. Staff told us how they actively reported any incidents that might have the potential to adversely impact on patient care. Concerns regarding the safeguarding of patients were passed on to the relevant authorities as quickly as possible. We were told there was an open and 'no blame' culture at the practice that encouraged staff to report adverse events and incidents.

The minutes of practice meetings we reviewed showed that new guidelines (for example National Institute for Health and Care Excellence (NICE)), complaints, incidents and significant events, were discussed. The staff we spoke with were positive about the use of incident analysis and how this assisted them to develop the care provided. Clinicians were confident that treatment approaches adopted followed best practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A standardised template was used for the reporting of all incidents. This included relevant categories of description of events, what went well, what could have been done better, what action has been agreed and what learning ensued. Each incident was rated as to the level of risk incurred. A summary log was also held of all events that occurred over the year.

We looked at the records of significant events that had occurred in the last 12 months. There was evidence that appropriate learning had taken place where necessary and that findings were disseminated to relevant staff at meetings and training and development days. There was evidence of annual review of significant events to analyse themes and trends in order to improve learning and practice. We saw that action plans for the significant events were revisited to ensure all actions were completed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

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. Significant events, incidents and complaints were investigated and reflected on by the GPs and practice manager. GPs told us significant event audits were included in their appraisals in order to reflect on their practice and identify any training or policy changes required for them and the practice. The team recognised the benefits of identifying any patient safety incidents and near misses.

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 the recent guidance on Ebola (Ebola is a contagious viral infection causing severe symptoms and is currently epidemic in West Africa) and nebuliser product issues (nebulisers are machines used in asthmatic conditions). They also told us relevant alerts were discussed at team meetings 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 up to date child and vulnerable adult safeguarding policies and supportive protocols and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse and at risk patients. The policies were easily available to staff on their computers and in hard copy. Staff had easy access to contact details for both child protection and adult safeguarding teams. We saw evidence of such information displayed in all clinical, reception and administrative areas.

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Are services safe?

All staff had received training in the last 12 months on safeguarding. Clinical staff had a higher level of training than other staff. All staff we spoke with were knowledgeable about the types of abuse to look out for and how to raise concerns. Staff were able to discuss examples of at risk children and how they were cared for. Staff were made aware through an alert system on the computer and electronic records of vulnerable people and their immediate families.

One of the GPs took the lead for safeguarding children and another GP led for adults. 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 leads attended local case conferences when able due to time constraints. They also completed reports when necessary. All staff we spoke to were aware who the lead for child protection was and who to speak to in the practice if they had a safeguarding concern. The safeguarding lead for children had a dedicated session each month to undertake safeguarding work. The lead GP was responsible for applying codes and alerts on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GPs were fully aware of the vulnerable children and adult patients at the practice. They had recently undertaken a review of child protection cases to identify any risks of child sexual exploitation within their patients in line with Cheshire East Local Safeguarding Board framework.

The practice had a current chaperone policy. Only clinical staff acted as a chaperone and they had received appropriate training for this role. A chaperone policy notice was displayed in the reception area and in all treatment and consultation rooms.

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 other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. All medicines that we checked were found to be in date.

Medicines for use in medical emergencies were kept securely in a cupboard in one of the treatment rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked for function regularly and checks recorded.

The practice employed two medicine technicians. Their role was to ensure patient safety in prescribing, including repeat prescribing. They had support from the practice GP lead in medicines management and from the medicines management team of the Clinical Commissioning Group (CCG) in keeping up to date with medication and prescribing trends. The CCG medicines management team visited the practice and regular meetings were held with them.

Spare prescription pads were stored securely. Prescription pads held in the printer within the treatment rooms were kept out of sight but not locked, however all treatment rooms were locked when unoccupied to reduce the possible risk of them being stolen. Repeat prescriptions were held securely in the administration office. We saw these were not pre signed. Prescriptions waiting for collection were monitored to ensure they had all been collected and patients were not missing their medication.

GPs reviewed their prescribing practices as and when medication alerts were received. Patient medicine reviews were undertaken on a regular basis depending on the nature and stability of their condition.

Cleanliness and infection control

Patients commented that the practice was clean and appeared hygienic. The practice had undertaken infection control audits in June and July 2014 on general management of infection, prevention and control and of hand hygiene. We saw that the outcome report from the audits were discussed (October 2014 meeting) with actions implemented. Cleaning was carried out under contract. The estates department who managed the premises monitored the cleaning schedule and standard of cleaning.

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Are services safe?

The practice nurse was lead for infection control. They had received training in infection control and this was updated annually.

There was an up-to-date infection control policy and associated procedures in place. A needle stick injury policy was in place, which outlined what to do and who to contact in the event of accidental injury. Needle stick injury flow charts were displayed in all treatment and consultation rooms. We saw current protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance and were in line with current best practice.

Infection control training was undertaken by all staff. Appropriate level of training and updates was evident for different roles (clinical and non-clinical). Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected the treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable. Privacy curtains in the treatment rooms were dated to identify when they were last replaced.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only. 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 estates department who managed the premises, ensured regular testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings) took place.

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. The estates department who managed the premises had contracts in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored in a separate cupboard. There was an oxygen cylinder, nebulisers and access to automated external defibrillators available at the medical centre. These were maintained and checked regularly.

Staffing and recruitment

An up to date recruitment and Disclosure and Barring Service (DBS) policy was in place. We looked at a sample of seven recruitment files for doctors, reception, administrative staff and practice nurses. The practice employed locum GPs. We saw evidence they independently checked the suitability of locum doctors as well as reviewing the NHS performer's lists.

We found that all the required information relating to workers was available in the staff files that we looked at. There were appropriate Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks for the clinical staff (including practice nurses and GPs). CRB and DBS checks for non-clinical staff had not been carried out; however these staff did not undertake chaperoning duties. Other required information seen included two references obtained prior to employment, evidence of relevant qualifications and training, contracts and job descriptions.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

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 need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead

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Are services safe?

roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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 weekly, monthly and annual checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see including fire marshals and first aiders. An up to date risk assessment log was seen. Each risk was assessed, rated and control measures recorded to reduce and manage the risk.

The premises were managed and maintained under contract by the estates department of the local NHS trust. We saw evidence in the form of contracts, service level agreements, risk assessments, compliance matrix and maintenance and check logs of the estates department ensuring the premises were well maintained and managed and that all statutory duties in respect of healthcare premises were undertaken. The estates department subcontracted some duties and these were also monitored effectively to ensure the premises were safe. Regular monitoring meetings took place with all the practices located in the medical centre.

The practice used electronic record systems that were protected by passwords and smart cards on the computer system.

Arrangements to deal with emergencies and major incidents

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system and by a portable alarm device. The medical centre had security personnel and procedures in place to deal with incidents such as aggressive behaviour.

A current business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice and by the practice manager and GPs. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment and medicines available. These were checked and maintained.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by a contracted company. A fire evacuation drill took place twice a year.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinicians were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered 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 of patients' needs and these were reviewed appropriately. NICE guidance was stored on the shared drive in the computer system so that staff had easy access to them. One of the GPs was lead at the practice for NICE guidelines. We saw evidence in meeting minutes and agendas for training days that NICE and other guidance was disseminated and discussed with all concerned. The practice had coding and alerts within the clinical 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 practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. GPs also specialised and led in clinical areas such as safeguarding, minor surgical procedures and various chronic diseases. Clinical meeting minutes demonstrated that staff discussed patient treatments and care and this supported staff to continually review and discuss new best practice guidelines.

The practice provided a service for all age groups. They provided services for people in the local community including an older than average population with a lower than average number of unemployed, patients living in more affluent areas and those experiencing long term health conditions with a higher than average life expectancy . We found GP's and other staff were familiar with the needs of each patient and the impact of the socio-economic environment. The practice had access to language translator services with which they had a contract. The practice nurses and GPs had completed accredited training around checking patient's physical health and around the management of various specific diseases.

Two of the GPs undertook joint injections and minor surgical procedures. One of the GPs provided an extended service for joint injections (for pain relief). This reduced referral rates to the local acute trust and provided more timely treatment and resolution of conditions. This service was also provided for house and bed bound patients and for younger people with sports injuries.

The practice referred patients appropriately to secondary care and other services. We saw that the practice's referral rates for healthcare conditions reflected the national standards for referral rates. All GPs we spoke with used national standards for referral, for example suspected cancers. Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP. In the absence of the named GP for the patient the duty doctor would assess and action any such information.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment including written consent for minor surgical procedures. One of the GPs undertook joint injections and minor surgical procedures. They did this in line with their registration and NICE guidance. The GP was appropriately trained to carry out this procedure and they ensured their skill and knowledge was kept up to date.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice performed averagely or above in comparison to local practices. The practice regularly monitored the Primary Care Quality Framework (PCQF) to identify all the practice performance areas. We discussed with the GPs and

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Are services effective?

(for example, treatment is effective)

they showed us data from the local CCG of the practice's performance against enhanced services. This was detailed and monitored performance indicators for primary care. They regularly benchmarked their performance to other locality practices.

Examples of clinical audits included; antipsychotic medication, anticoagulation in Atrial Fibrillation, and services for registered patients in nursing homes. The practice showed us some of the clinical audits that had been undertaken in the last 12 months. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The practice also had a programme of quality improvement which included reviews, such as, of services for patients with Coeliac disease, provision of a practice vascular Doppler service and proactive care for patients at risk of admission to hospital. The GP who undertook joint injections also audited their work and the pain scores of patient's pre and post injection to monitor effectiveness.

Clinical audits were often linked to medicines management, local Clinical Commissioning Group (CCG) enhanced service provision and locality performance indicators. As an example, we saw an audit of monitoring of gastrointestinal referrals undertaken as part of the local enhanced service, to ensure suitable use of the direct endoscopy service. Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they received feedback through training days and at meetings.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and reporting, clinical audit and reviews, managing child and adult safeguarding and medicines management.

The practice implemented the gold standards framework for end of life care. One of the GPs took the lead for this group of patients supported by the practice nurse and administration. They had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of these meetings. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

The induction programme covered a wide range of topics including policies and procedures, confidentiality, staff training, organisational induction and role specific induction. We saw examples in four of the more recent employee's induction (including GPs and administrative staff). The checklists were complete and had been signed by the manager and staff member.

We saw the mandatory training matrix which identified which subjects should be undertaken by which roles and the required frequency. The training matrix demonstrated that all staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of vulnerable adults and children. Staff also had access to additional training related to their role. For example reception staff had received conflict resolution and customer care training. Staff we spoke with told us they felt they were well trained and received good support to undertake training including that which was required by the practice and for training and development personal to their role. This confirmed that staff had the knowledge and skills required to carry out their roles.

We found that all staff had received an annual appraisal. Staff had supervision on an informal and formal basis including one to one and group sessions. A GP registrar told us they had received a good induction and was well supported and supervised at the practice. The administrative staff also told us they were well-supported by their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice.

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. There was a rota for their supervision and their clinical practice was reviewed regularly. We received positive feedback from the trainee we spoke with.

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).

Good

Are services effective?

(for example, treatment is effective)

The practice nurses performed defined duties and extended roles. They were able to demonstrate that they were appropriately trained to fulfil these duties. For example, administration of vaccines and cervical cytology.

The practice ensured that all of the clinical equipment used in the practice was regularly calibrated and that relevant staff were competent to use it.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. We were shown how the practice provided the 'out of hours' service with 'special' information notes, to support, for example, end of life care. Information received from other agencies, for example accident and emergency department or hospital outpatient departments were read and actioned by the GPs in a timely manner. Information was scanned onto electronic patient records in a timely manner.

The practice worked closely with other health care providers in the local area. The GPs and the practice manager attended various meetings for management and clinical staff involving practices across Eastern Cheshire CCG and in particular the six practices within the medical centre. These meetings shared information, good practice and national developments and guidelines for implementation and consideration. They were monitored through performance indicators and practices were benchmarked.

The practice attended various multidisciplinary team meetings at regular intervals such as to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by community staff such as district nurses, health visitors, social workers and palliative care nurses. Decisions about care planning were documented.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's 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 to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. They gave examples in their practice of when best interest decisions were made and mental capacity was assessed. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the capacity to consent to medical examination and treatment). The consent policy and procedures included Gillick competency and how to assess this.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and joint injections a patient's written consent was obtained and documented in the patient notes.

Health promotion and prevention

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

Within the medical centre and utilised by all the practices, a voluntary group called the Friends of Waters Green Medical Centre operated. This group provided signposting information to support services advising in health promotion. They would often hold awareness and health promotion events for diseases such as breast cancer, bowel cancer and for smoking cessation. Staff we spoke with were knowledgeable about advisory and support services and how to access them.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. For example, patients on disease registers were offered reviews with the nurse.

The practice offered a health check to all new patients registering with the practice and also offered NHS Health

Good

Are services effective?

(for example, treatment is effective)

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 the majority of children's immunisations was above average for the CCG. Seasonal flu immunisation rates for the over 65 group were also above average for the CCG. Last year the practice had achieved excellent uptake rates of flu vaccination for patients in clinical at risk groups, over 65years old and pregnant women.

One of the GPs provided sports injury prevention advice to younger patients and those sporting patients in vulnerable circumstances enhanced by their particular lifestyle.

The practice had ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual health check. There were local health and support groups that they accessed and referred patients with mental health and learning disabilities needs.

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. They had all received training in privacy and dignity; this was updated on a regular basis. Screens had been put in place to help the issue of privacy and overhearing conversations at the reception desk. There was a room available if patients wished to discuss something with them away from the reception area and a notice on reception advising of this. The computers at reception were shielded by a screen and the level of the desk to help maintain patient confidentiality.

Consultations took place in purposely designed rooms with an appropriate couch for examinations and screens 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.

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms. Staff we spoke with were knowledgeable about the role of the chaperone and had received training to carry out this work.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decisions about their own treatment, they received full explanations about diagnosis and treatments and that staff listened to them and gave them time to think about decisions. This was reflected in the patient survey results.

We saw that healthcare professionals were knowledgeable about and adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's' legal guardians. One of the GPs was the lead for the registered patients living in the practice allocated nursing homes. Within this role they were involved in advance care planning, Do Not Attempt Resuscitation (DNAR) decision making, capacity assessments and power of attorney decisions. The GP had received training for this and was supported by the locality GPs nursing home group which met quarterly.

The practice had a data protection and access to records policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients on the practice website and in leaflets.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the care they received from the practice. Patients we spoke with told us they had enough time to discuss things fully with the GP and most patients felt listened to and felt clinicians were empathetic and compassionate. They told us all the staff were compassionate and caring.

The practice had a GP lead for patients nearing the end of life and those who were terminally ill and they were supported by the practice nurse. They had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care and support needs of patients and their families. We saw evidence of these meetings minutes. Special notes were used to inform out of hours services of any particular needs of patients who were coming towards the end of their lives.

GPs and clinical staff had a method of identifying and supporting bereaved patients through the flag system on the medical records. The voluntary group, (Friends of Waters Green Medical Centre), were present in the centre every day. They were able to provide support and signposting patients to other groups including bereavement support.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice 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. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

The practice cared for a number of elderly adult patients who lived in a local care home. One of the GPs was lead for these patients and undertook a visit each week to review care plans, any new patients and medications. 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 had an active Patient Participation Group (PPG). We spoke with a member of the group and looked at their annual report and meeting minutes. The practice manager and a GP attended the PPG meetings on a regular basis where good information exchange took place. The PPG told us the practice listened to them and they were able to contribute views and suggestions that, if appropriate, were acted upon. For example, the use of screens for privacy in reception. There was a suggestions box located in reception which the PPG monitored and fed back to the practice any issues.

Tackling inequity and promoting equality

The practice was aware of the challenges they faced with their population. They are situated in an affluent area of Cheshire with a higher than average elderly population. This presents its own health challenges with a higher than average number of patients with long term conditions and co-morbidity.

The practice ethos strived to provide quality care to all patients taking into account their diverse needs. 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. Translation service notices were displayed in each room and staff had access to the service direct. The practice provided equality and diversity training for all staff. Records we saw demonstrated that all staff had completed the required training and were up to date.

The premises and services met the needs of people with disabilities. The medical centre was purpose built and met the standards for disability access across all areas. There were disabled parking, toilet facilities and baby changing facilities available. There was an audio loop system in place in reception and they had access to sign language interpreters. A specific information leaflet for patients with hearing loss was available at the practice. A recent audit had been undertaken to demonstrate accessibility for hard of hearing patients, any areas for action were addressed. The practice scored very well for access and provision of service for hard of hearing patients.

The practice demonstrated how they supported patients who had no fixed abode. There were flags on their records so that if someone who was homeless rang in to the practice they would be diverted straight away to clinical staff, usually the nurse, to be dealt with. This ensured they were not missed if they needed help or care.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. This was the practice manager, although they did liaise 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. Complaints were investigated thoroughly. A summary and overview log was recorded which broke down the complaints into subjects

Good

Are services responsive to people's needs?

(for example, to feedback?)

and themes. Complaints were reviewed annually to analyse themes and trends in order to improve learning and practice. We saw evidence of this in training and development day's agenda and minutes.

Patients we spoke with were all aware of the complaints procedure. An appropriate information leaflet detailing the process for making complaints or comments about the practice was available to take away at the reception desk. Staff we spoke with were trained in customer care, conflict resolution and complaint handling and were able to tell us how they would handle initial complaints made at reception or by telephone.

Access to the service

The practice was open Monday to Friday 8.00am until 6.30pm. They were closed one half day eight times per year 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 advise/appointments out of normal working hours when the practice was closed such as contact details for the out of hours medical provider. The practice offered pre bookable and urgent (on the day) appointments, telephone consultations and home visits. Appointments could be made in person, by phone or online. One person we spoke with, of working age, told us the online booking system was good and useful.

Patients whom we spoke with, comment cards and patient survey results told us they there was difficulty getting through to the practice on the telephone for appointments and general information. The practice had identified there was a problem with the telephone lines; however although the practice had acknowledged the feedback from patients, more work was needed to improve the service. Patients told us that the phone lines were engaged constantly. The practice performed poorly in patient surveys for access to the appointments system with only 37% saying they found it easy to through to the practice by phone and 52% described their experience of making an appointment as good. Overall satisfaction with the practice (at the last patient survey) was low; however this was attributed to the concerns around the phone and appointment systems. The survey overall demonstrated good satisfaction with all staff and the way patients were cared for and treated.

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

The practice worked closely with other health and social services in provision of additional GP services to a number of care providers for elderly and mentally infirm patients. Patients with poor mental health received annual health checks and had care plans in place, as did those elderly patients living in the local care home. The practice provided services to a group of patients with learning disabilities living in a local charity's residential care. They provided training and health promotion for carers and health checks for patients. The practice provided additional services to a local independent psychiatric hospital and GP services to the mental health trust units for adults with severe learning disabilities.

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

Staff were able to articulate the vision and values of the practice. The practice had a clear vision to support patients to stay healthy and to provide a high quality, patient centred care to them if they were unwell. The GP partners worked together to develop a strategy and were currently planning for support to the senior partners when one retired next year. There was a practice agreement in place between the partners.

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 in the offices. Policies and procedures were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them. Staff could describe in detail some of the policies that governed how they worked for example the safeguarding children's policy and procedures.

There was a clear organisational and leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a GP partner was the lead for safeguarding, one for nursing home patients, one for musculoskeletal and joint injections and another was lead for learning disability. We spoke with staff of varying 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. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. For 2013/14 the practice obtained 94.5%. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Clinical audits were undertaken regularly by nursing and medical staff. We looked at a selection of these. Generally they were completed well; with review of actions and improvements evident. Audits undertaken by the clinical staff were mostly decided on either by local CCG or national priorities. Most of the audits followed a standard format, were stored for sharing on the shared drive of the computer with actions and improvements from the audits discussed at team meetings and training and development days.

The practice had arrangements in place for identifying and managing risks. Risk assessments and risk management was in place with support from health and safety representatives and premises management personnel (from the estates department of the local NHS trust).

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership which articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They 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 their views about how to develop the service acted upon.

The practice held a number of various meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

We looked at complaints and found they were well managed. The practice investigated and responded to them in a timely manner, and complainants were satisfied with the outcomes. They were discussed at staff meetings and were used to ensure staff learned from the event.

There was an active Patient Participation Group (PPG) which had a good relationship with the practice. They felt listened to and valued with the practice acting on suggestions put forward by the PPG where appropriate. A suggestion box was situated in the reception area to

Are services well-led?

Good

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

encourage patient feedback. A leaflet was on reception and was handed out to patients encouraging them to access and 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.

There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events. The practice gathered feedback from staff through 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 monthly meetings were held at which staff had the opportunity and were happy to raise any suggestions or concerns they had. A staff suggestion box was evident to encourage staff to put their views forward.

Management lead through learning and improvement

We saw that all staff were up to date with annual appraisals which included looking at their performance and development needs. The practice had an induction programme and a training and development policy and procedures to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff undertook a wide range of relevant training. Mandatory training was up to date for all staff.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The practice management monitored staff training. We saw that a training matrix for staff employed in the organisation was in place to monitor compliance with the training policy.

The practice was a GP training practice. There was two GP registrars who was supported by two GP trainers and the other GPs at the practice. We spoke with one of the GP registrars who told us they were well supported by the GPs and rest of the staff.