Earnswood Medical Centre

Quality Report

Eagle Bridge Health & Wellbeing Centre
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Date of inspection visit: 13 October 2015
Date of publication: 29/12/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Earnswood Medical Centre on 13 October 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patient's needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they did not find it easy to make an appointment with a named GP, however there was continuity of care, with urgent appointments available the same day. The practice had recognised the need to improve access to appointments and was working to improve this.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and most staff felt generally well supported by management. However, nursing staff had been adversely affected by several colleagues having left the practice recently, leaving them feeling somewhat unsupported.

Summary of findings

- The practice proactively sought feedback from staff and patients. The management had been slow to react to pressure from patients to improve access to appointments.

We saw one area of outstanding practice:

- The practice provided very personal and patient centred care to elderly people living in care homes in the locality. GPs made very regular visits to homes and provided care home management with their personal contact details in order that they could provide advice outside surgery hours.

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

Importantly the provider MUST:

- Review and improve access and availability of routine patient appointments.

Additionally the provider should:

- Produce and embed a mission statement or vision for the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care

Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing people's mental capacity when this was required and promoting good health, training in these subjects had been effective. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked effectively with multidisciplinary teams and other services.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available to them was easy to understand. Information about patient's conditions was provided and GPs were willing to make ad hoc telephone calls to support patients. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was proactive in initiating and becoming part of local projects to improve outcomes for patients. Patients said they found it sometimes difficult to make an appointment with a GP or nurse.

Summary of findings

The practice had been slow to respond to patient feedback on this, but more recently had been working with NHS England to identify methods of improving patient access. Urgent appointments were available the same day. The practice had very good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence that learning from complaints had been shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Management were clear about the practice aims, however there was no documented mission statement or vision for the practice. Some staff were less clear about the vision and their responsibilities in relation to this, but they told us they wanted to provide the best patient care possible. There was a clear leadership structure and most staff felt supported by management. Some nurses had felt less supported due to senior nursing staff having recently left the practice, recruitment to replace staff was on-going. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on, the practice, had been slow to respond to feedback about difficulty accessing appointments. The patient participation group (PPG) was active. Staff had received an induction, regular annual appraisal and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Some of the GPs provided personal contact details to local care homes supported by the practice, in order that they could be contacted for advice and guidance outside surgery hours. Some practice staff had received specific training and had acquired high skill levels in dementia care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were on the “at risk” register. Immunisation rates were relatively high for all standard childhood immunisations. These were close to the average for other practices in their Clinical Commissioning Group (CCG). Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and district nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours; some additional training around whistleblowing was planned.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The National GP Patient Survey results published on 6 July 2015 showed the practice was mostly performing in line with local and national averages. There were 118 responses which represents 38% of the questionnaires sent out. We reviewed 17 CQC comment cards collected in the two weeks prior to the inspection.

- 21% find it easy to get through to this practice by phone compared with a CCG average of 62% and a national average of 73%. The practice had recognised the need to improve this figure and were working with the CCG to improve access to appointments.
- 89% said the last GP they saw or spoke to was good at listening to them compared with a CCG average of 89% and a national average of 89%.
- 67% find the receptionists at this practice helpful compared with a CCG average of 84% and a national average of 87%.
- 85% said the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 87% and a national average of 87%.
- 72% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 84% and a national average of 85%.
- 79% say the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 46% describe their experience of making an appointment as good compared with a CCG average of 68% and a national average of 73%.
- 50% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 59% and a national average of 65%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards which were all positive about the standard of care received. There were a number of comments relating to poor access to appointments.

Areas for improvement

Action the service MUST take to improve

Review and improve access and availability of routine patient appointments.

Action the service SHOULD take to improve

Produce and embed a mission statement or vision for the practice.

Outstanding practice

The practice provided very personal and patient centred care to elderly people living in care homes in the locality.

GPs made very regular visits to homes and provided care home management with their personal contact details in order that they could provide advice outside surgery hours.

Earnswood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector, an additional CQC Inspector and three specialist advisors; a GP, a nurse and a practice manager. Our inspection team also included an expert by experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Earnswood Medical Centre

Earnswood Medical Centre provides primary medical services to approximately 15,000 patients in the catchment area of Crewe and surrounding rural areas. Services are provided from a purpose built building on the outskirts of Crewe town centre under a General Medical Services (GMS) contract. Co-located with the practice are a number of other services, including podiatry, dentistry, physiotherapy, pharmacy and help groups.

There are six GP principles and two salaried GPs (four male and four female), and patients can be seen by a male or female GP as they choose. This is a training practice with two GP trainers; there is currently one registrar at the practice. There is a team of six nursing and healthcare assistant staff. They are supported by a team of management, reception and administrative staff.

The practice is open between 8:00am and 6:30pm Monday to Friday. Appointments are available 8:00am to 6:00pm Monday to Friday. Extended hours surgeries are offered on Tuesday from 7:30am to 6:00pm.

From the 1 October 2015 the practice had, in consultation with NHS England begun to use NHS 111 to access it's out of hours service so that patients had access to care when the surgery was closed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

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

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

How we carried out this inspection

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

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

Detailed findings

• Is it well-led?

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

The population groups are:

• Older people

• People with long-term conditions

• Families, children and young people

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

• People living in vulnerable circumstances

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

Before our inspection we carried out an analysis of 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. We carried out an announced inspection on 13 October 2015.

During our visit we spoke with two GPs, one nurse, a health care support worker, the Practice Manager and reception staff. We also spoke with four members of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the practice.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and any serious issues were automatically treated as a significant event. The practice carried out an analysis of the significant events and this also formed part of the GPs' individual revalidation process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an alarm activation by one of the staff was not appropriately responded to, the incident was discussed and an action plan implemented, including additional staff training to prevent any further occurrences.

Safety was monitored using information from a range of sources, including National Patient Safety Agency (NPSA) and National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medication management and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding. The GP attended bi monthly safeguarding meetings and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. Some staff were not clear who they could contact outside the organisation if they wished to provide "whistleblowing" information. We were told further training would be provided to address this and we saw that a policy was available for staff to refer to.
- A notice was displayed in the waiting room and treatment rooms, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The nurse manager had been the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice, she had recently left the practice and a replacement was actively being sought. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There were arrangements for managing medicines, including emergency drugs and vaccinations, in the practice to keep patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored, however improvements in monitoring prescriptions were required, and we were told that better systems would be introduced immediately. The practice made effective use of prescribing software so

there were appropriate alerts which were kept up to date. There were fewer paper requests resulting in less chance of prescription requests being lost and therefore there was a visible audit trail.

- Recruitment checks were carried out and the two staff files we sampled showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty, the practice had recently taken on an apprentice to focus on note taking to free other staff from the task and ensure that good documentation was of a high standard.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training, there were emergency medicines available and one of the GPs was a First Aid trainer. The practice had several defibrillators available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice carried out assessments and treatment in line with NICE best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice achieved good results in diabetes care. For example, patients with diabetes, on the register, who had influenza immunisation in the preceding year, was 99.7% compared with a national average of 94.5%. The practice ensured that guidelines were followed through risk assessments, audits and random sample checks of patient records.

Patient's' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records and audits to ensure it met the practices' responsibilities within legislation and followed relevant national guidance. We spoke with management at a local care home for elderly people, they were very complimentary about the manner in which the GPs carried out their responsibilities in relation to capacity and consent, they told us that GPs were fastidious in documenting consent and best interest decisions on the home's care records.

Protecting and improving patient health

GPs at the practice had a varied skill mix to support effective care of their patients. These included a family planning tutor, an advanced life support instructor, an occupational health doctor, a trained hypnotherapist, a trained disability analyst and a GP with skills in sign language. Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. A dietician was available within the practice complex and smoking cessation advice was available from practice staff and from a local support group. GPs told us that effective care was demonstrated by the fact that at one 71 bed care home where they looked after the elderly patients, there had only been 5 hospital admissions in the previous 12 months; this was confirmed by the care home manager.

The practice's uptake for the cervical screening programme was 72.2%, which was comparable with the national average of 81.8%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under twos averaged 93.7% whereas the CCG average was 96.2%. Flu vaccination rates for the over 65s were 72.8%, and at risk groups 51.8%. These were also comparable to national averages of 73.2% and 52.3% respectively.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-up on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice had good continuity of care, some of the GPs had initially trained at the practice and returned to stay for many years. The staff turnover at the practice was very low and communication between the clinicians was effective with daily informal morning meetings and with an open door policy for those seeking advice.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and intranet system. This included access to care and risk assessments, care plans, medical records and test results. Information such as self-help weight management, smoking cessation and other NHS patient information leaflets were also available.

Good

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred to, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated. Some staff felt that there could have been more inclusion in meetings and management agreed that a strategic review of meetings, their subject matter and attendees was needed, including better documentation of all meetings held. The practice was engaged with the local GP practice federation and had received funding through the Prime Minister's challenge fund to improve access. They were looking how to manage 7 day access.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 96.5% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets.

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average 83.65% opposed to the national average of 83.1%.
- Performance for mental health related and hypertension indicators was similar to the national average. The average of four of the main indicators showed the practice average to be 88.2% as opposed to the national average of 88.4%.
- The dementia diagnosis rate was comparable to the national average with a 78.9% practice average as opposed to 83.8 national average.

Clinical audits were carried out and all relevant staff were involved to improve care and treatment and people's outcomes. There had been several clinical audits completed in the last two years, one of these was a completed audit where the improvements made had been checked and monitored. The lead GP agreed that more complete audits needed to be completed in order to make them more effective. Findings were used by the practice to improve services. For example, recent action taken as a result of auditing included improvements in the number of medication reviews completed by the practice. The practice had identified the need to better assess the prescribing process around medications after patients had been discharged from hospital.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality. There was an ethos of continual learning at the practice, for example the PPG had noted that the an email sent out to a number of patients relating to customer satisfaction had led to patient email addresses being visible to other patients in the group receiving the email. The practice manager had identified that further training was required for some staff in order to prevent a reoccurrence. One of the GPs who had recently returned to work told us that the support they had received had been of the highest order and that because of this the return to work had been much smoother than expected.
- The learning needs of staff were identified through a system of appraisals and meetings., No formal supervision meetings were being held between annual appraisals, the practice manager said that this would be addressed immediately. Staff had access to appropriate training to meet learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, coaching and mentoring, clinical supervision, and facilitation and support for the revalidation of doctors. Protected learning time was available for all staff to assist in their training and development. We saw that all staff had undergone an appraisal within the last 12 months.

Staff received training that included: safeguarding, fire procedures, basic life support and information governance

Good

Are services effective?

(for example, treatment is effective)

awareness. Staff had access to and made use of e-learning training modules, external and in- house training. All staff had access to practice policies on the shared area of the practice computer system.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. There had been some negative feedback provided through the GP survey around the poor attitude of some receptionists. The practice had arranged for some on line and clinical commissioning group (CCG) supported face to face customer service training for its reception staff. Curtains were provided in consulting rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

All of the 17 patient CQC comment cards we received were positive about the service experienced, other than problems with access to appointments. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with four members of the PPG on the day of our inspection. They also told us they were not satisfied with the access to appointments and had been disappointed with the speed at which the practice had responded to patient feedback on the subject. They said they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was also a separate area for patients to sit away from the main waiting area should they prefer. We noted that the practice was mindful of individual needs, for example not displaying patient names on the electronic waiting board when this had been requested this. Notices in the patient waiting room told patients how to access a number of support groups and organisations. 67% patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

The practice's computer system alerted GPs if a patient was also a carer. There was a carer's register and carers were being supported, for example, by offering health checks. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their GP would contact them, particularly if they knew family support was not immediately available. Staff at the practice would also be alerted to any deaths of patients at the practice so that they would be mindful and able to offer support where possible or by giving people advice on how to find a support service.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was comparable with other practices in the area for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% said the last GP they saw or spoke to was good at listening to them compared with a CCG average of 89% and a national average of 89%.
- 85% said the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 87% and a national average of 87%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 82% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

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 making decisions 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%

The lead GP told us how in recent years there had been a large increase in patients from eastern Europe (30% of patients); this had led to the practice having to respond to the need of patients whose first language was not English. Staff told us that translation services were available for patients who did not have English as a first language and these were regularly used with translators asked to arrive just before appointments where they were required. We saw notices in the reception areas informing patents this service was available. We noted the home screen of the electronic patient booking in service was in English and only when a patient booked in, did language options become available. The practice worked closely with a local Polish interpreter who was able to provide practice staff with information about Polish customs and cultural differences to help staff provide a better response to patient's needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example, work was ongoing with the South Cheshire CCG Practice Engagement and local change Officer in relation to the problem of patients accessing appointments. We spoke to this person and they told us that the practice had recently been working hard to resolve the problem, had accepted they had been slow to respond to the issue and now saw it as a priority. They told us that they were confident that together they would be able to improve patient access to appointments.

There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. Members of the PPG were present during the inspection and we spent time speaking to them, it was clear they were very passionate about the service patients received.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice offered early appointments on a Tuesday morning from 7.30am for working patients who could not attend during normal opening hours. Occupational medical checks were available to patients who were taxi drivers, heavy good vehicles (HGV) and public service vehicle (PSV) drivers.
- There were longer appointments available for people with a learning disability or more complex needs.
- Home visits were available for older patients or other patients who would benefit from these.
- Two of the GPs made visits to a local nursing home three times a week.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice had a lift to all floors within the complex.
- The practice offered a "Patient Information Exchange" this was run by a trained member of the PPG, who was able to offer additional advice and guidance to patients.
- A variety of services were available within the complex where the practice was located, including podiatry, dentistry, physiotherapy and pharmacy.
- One of the GPs was trained in basic sign language and was able to communicate more readily with those patients who found it easier to communicate by this method.
- There were contraceptive clinics, midwife clinics, drug misuse clinics, smoking cessation clinics, breast feeding facilities as well as a minor operation clinic.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.00am to 6.00pm daily, with an early surgery from 7.30am on Tuesdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available. We saw that 15 of the appointments blocked out as 'urgent appointments' had not been used on the day of our inspection. We spoke to the management team about this and they said that this would be investigated as part of their review of access to appointments, triage service and telephony review. The practice had recognised that access was the single major issue that required resolving and was dedicating resources and working with the CCG to make improvements as quickly as possible.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than the local and national averages. For example:

- 66% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 21% patients said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 73%.
- 46% patients described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%.
- 50% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 59% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

Good

Are services responsive to people's needs?

(for example, to feedback?)

line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Staff we spoke to said they were confident in handling complaints and always recorded them so that the practice was aware of any issues even if they were relatively minor.

We saw that information was available to help patients understand the complaints system. A complaints form was available as were notices in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw 38 complaints had been received in the last 12 months and found they had been handled in an appropriate manner. A review of the complaints had identified four main trends, one of which was poor access to appointments.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice told us their vision was to deliver high quality care and promote good outcomes for patients; this was encapsulated in their statement of purpose provided to the CQC. The practice did not currently have a mission statement, the practice manager told us that plans were in place to formulate one as soon as possible. Some members of staff at the practice were not aware if there was a mission statement or not, however they were clear that they wanted to provide the best care that they could to their patients.

Staff told us they felt valued and well supported and knew who to go to in the practice with any concerns. Staff were aware of which GP had specific responsibility for which area, for instance safeguarding and diabetes. The reception team had worked together for several years and had been afforded opportunities to develop within their role. They told us that staff tended not to want to leave once they started working at the practice such was the level of job satisfaction, this was reflected in the low levels of staff turnover. The culture at the practice was one that was open and fair and this was very apparent when we spoke to staff. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and health and safety, which were in place to support staff. Staff we spoke with knew where to find these policies if they required them for review.

Governance arrangements

The practice had an overarching clinical governance policy with one of the GPs having specific responsibility for this.

Governance on matters not clinically related were the responsibility of another GP who attended a number of forums including those attended by other service providers located in the same complex as the practice.

Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of their own roles and responsibilities.
- Practice specific policies that were implemented and that all staff could access.
- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place.
- A system of audit cycles which demonstrated an improvement on patient's' welfare. The practice had plans to improve and expand their auditing regime.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- Proactively gaining patient's feedback and engaging patients in the delivery of the service. Acting on any concerns raised by both patients and staff.
- The GPs were all supported to address their professional development needs for revalidation and all staff in were supported through appraisal schemes and continuing professional development.
- The GPs, clinical staff and support staff had learnt from incidents and complaints, this process was transparent in nature.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider is failing to meet this regulation as it has not acted on repeated feedback from patients about the lack of access to appointments and difficulty in getting through on the telephone. This can be seen by a number of complaints received and reviewed by the practice relating to access, feedback from the PPG and the results of the last GP survey, "21% find it easy to get through to this practice by phone compared with a CCG average of 62% and a national average of 73%."** **Regulation 17 states:** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; C. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; D. maintain securely such other records as are necessary to be kept in relation to— a. persons employed in the carrying on of the regulated activity, and

This section is primarily information for the provider

Requirement notices

b. the management of the regulated activity;

E. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

F. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

3. The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

A. a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

B. any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.