The Schoolhouse Surgery

Quality Report

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

Ratings

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

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 The Schoolhouse Surgery. Our inspection was a planned comprehensive inspection, which took place on 4 December 2014. The Schoolhouse Surgery delivers services under a Primary Medical Services (PMS) contract.

The service provided by The Schoolhouse Surgery is rated as outstanding.

Our inspection showed all care and treatment was safe, effective, caring and well-led.

Our key findings were as follows:

- The practice provides safe care and treatment to its patients. The practice had systems in place to identify report and investigate any serious incidents. Patient safety was upheld and protected by all clinicians.
- The practice delivered evidenced based care and treatment which was shown to be effective through the monitoring and review of patient outcomes.
- We saw and were told by patients that the practice and staff were responsive to feedback and that patients felt privileged to be treated by clinicians at the practice
- The practice and all staff were well-led; a clear vision and strategy was in place to deliver the best possible care and treatment for patients.

We saw several areas of outstanding practice including:

- Audits were targeted and carried out in response to data or reports on clinical findings. Examples we saw of completed audit cycles showed patient outcomes were improved; rates of hospital admissions from nursing and care homes dropped significantly and the length of any patient stay in hospital was also reduced.
- GPs had a clear vision and this was shared by all staff. The partners recognised that engagement with patients, beyond time spent in the consulting room was key in getting health initiatives off the ground. GP's encouraged families and young people to use technology to help make health and lifestyle decisions. Examples included use of applications on computers or smart phones to help calculate calorie intake, or the use of pedometers to measure the contribution community walks made to exercise needed each day. GP registrars on training placement with the practice were taught to 'view excellence as the norm rather than the exceptional'.

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- The practice included **all** community stakeholders in their weekly practice meetings, for example community pharmacists and managers and carers from the local domiciliary care agency. Evidence was available to demonstrate that this reduced the instance of more vulnerable patients being re-admitted to hospital care.
- GPs at the practice were committed to providing support to older patients who wished to remain at home rather than be admitted to hospital. Patients receiving palliative or end of life care were helped to make advanced decisions about their care and treatment, which were recorded. GPs were innovative in the use of technology to ensure those patients whose verbal skills were impaired by illness, could communicate their wishes.

On the basis of the findings of this inspection the provider is rated outstanding.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had systems in place to keep all patients safe. All staff demonstrated a good understanding of safeguarding, the Mental Capacity Act 2005 and the importance of consent to care and treatment. The practice had responded quickly to any incidents and we saw how learning from incidents was shared with the wider healthcare community, for example NHS England and the General Medical Council. Patient safety was the priority in all that the practice did. Risk assessments were in place where patients with complex health conditions had expressed a wish to be treated at home rather than be admitted to hospital. The practice worked with each community stakeholder to ensure treatment delivered met patients' needs, whilst sharing with patients any risks involved in their treatment.

Are services effective?

Outstanding

The practice is rated as outstanding for the provision of effective treatment. The practice delivered evidence based care and treatment and followed the latest published best practice guidance. GPs and practice nurses met with all stakeholders at multi-disciplinary team meetings, held by the practice on a weekly basis. The managers of the local domiciliary care agency and local community pharmacists were also considered part of the multi-disciplinary team. The team worked together to ensure that when any patient was discharged from hospital, all support services were in place and any newly prescribed medicines were available when needed. The practice was able to demonstrate how this approach had significantly reduced re-admission to hospital of vulnerable patients.

Are services caring?

Good

The practice is rated as good for providing caring services. We received 31 Care Quality Commission (CQC) comment cards. Of these, 30 cards described positive experiences of care and treatment at the practice over a number of years. One card described a negative experience. We were able to spend time talking to seven patients who told us that the service they received was 'unbeatable'. Patients told us they valued the continuity of care they received from the GPs and nursing staff. One patient told us they felt privileged to be treated by such caring staff. We saw several examples where GPs had supported terminally ill patients in the making of significant decisions about their care and treatment. All stakeholders had been

Summary of findings

involved in the process, including were appropriate, carers and family members. Families and carers specifically commented on how this had helped them and their family member at that difficult time.

Are services responsive to people's needs?

Good

The practice is rated as good for being responsive to patients' needs. The practice had responded to patient feedback on being able to book appointments and order repeat prescriptions on-line, and this facility had been available to patients for the past six months. By working with three other nearby practices to share resource, more services had been made available to patients at the practice, for example ultrasound scans, audiology, ophthalmology and podiatry. This practice is in a semi-rural area and this step had reduced the need for patients to travel considerable distances to access these services, some of which had only been available at the local hospital.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led We saw clear lines of accountability in place throughout the practice. The practice manager led the administrative support staff who provided high quality support to clinicians. All staff had received training beyond what is considered as mandatory. Staff showed a commitment to the vision of the practice, and felt they played a part in the delivery of safe, compassionate care and treatment. The Schoolhouse Surgery is a training practice. The partners provided clinical leadership to GP registrars. The registrar who was at the practice on the day of our inspection told us they were well supported and encouraged by the partners to 'view excellence as the norm rather than the exceptional' for delivery of patient care and treatment. Practice partners recognised that engagement with patients beyond time spent in the consulting room was key in leading patients to better health and improved lifestyle choices. The partners had recently taken a CCG initiative to encourage walking, to a personalised and community level. Initial results had been positive. The partners were using simple technology to promote learning about the effects of healthier lifestyles, especially to engage with children and families at the earliest possible opportunity. The practice had recognised and valued the enthusiasm of the Patient Participant Group (PPG) who had helped in the launch of this initiative.

A partner at the practice had been a finalist in the national GP of the Year Awards 2014.

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

Outstanding

The practice is rated as outstanding for the care of older patients. GPs' supported patients in two nearby residential care homes and two nursing homes. Weekly 'ward rounds' at the nursing homes by the GPs meant that patients received pro-active care and treatment. Work carried out by one of the partners at a care home was highlighted by the Clinical Commissioning Group (CCG) for the way in which admissions to hospitals had been significantly reduced and the positive impact of this on the well-being of patients. The manager and care co-ordinator from one of the local care homes had seen posters advising of our inspection and came to the practice to talk to us about the level of outstanding support patients at the home received from the practice.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of patients with long term conditions. In the most recent Patient Survey results (2013-14), all responses to questions asked of patients with long-term conditions were positive and the practice scored higher than the England average and the average scores of other practices within Eastern Cheshire. Patients commented that the nurse gave them enough time (84.2%), that the nurse listened to them (84.7%), that the nurse explained test results to them (82.0%), and that they had confidence and trust in the nurses at the practice (92.5%). We saw several examples of outstanding care and treatment particularly for patients who had chronic, degenerative illnesses, with regard to helping patients make informed decisions about their future care, and where and how this could be delivered. The clinical team at the practice had been nominated for, and were finalists at the National General Practice Awards 2014 in recognition of their successful treatment, support and management of patients' long term conditions.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. All practice staff showed a good understanding of consent issues and Gillick competency for those patients who attended the practice without an adult. Health visitors and midwives visited the practice on a regular basis to see patients who required their services. All community health care professionals were invited to and attended meetings at the practice, to discuss patient care. A chaperone policy was in place and this service was advertised in practice leaflets and on notice boards in reception and waiting

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areas. Patients we spoke to from this population group told us they had always be seen by a GP 'on the day' if they had needed to. Patients we were able to speak to on the day of our inspection told us the practice was central to the community. Patients described how the GPs and nurses worked hard to help them take ownership of their health, encouraging them to take part in activities and interests that would boost their overall health and well-being. We spoke to a patient who had recently become a parent; they told us GPs were always understanding of their concerns, were patient and listened to them giving enough time for them to talk about their concerns.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working age patients and those recently retired. The practice opening times and availability of GPs met the needs of this population group. Reception staff had the autonomy to offer lunch time appointments if working age people required them. Appointments with the practice nurses were also available during these surgeries. The practice recently moved to an on-line system of booking appointments which was something that working age patients had requested. Repeat prescriptions could also be ordered on line. A number of clinics and services were available at the practice, including minor surgery, joint injections, dermatology, and scans. Working age patients and those recently retired told us this was particularly valuable to them.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of vulnerable patient groups. The practice supported a residential centre close by for adult patients with learning disabilities. Following introduction of new guidelines from the Royal College of General Practitioners on the care and support of patients with a learning disability, the practice carried out an audit and review of care for patients in this population group. As a result, a far more comprehensive health review for these patients was formulated and delivered annually, with more focus on identifying health conditions in their early stages and screening for syndrome specific illness. The practice demonstrated how it had adapted communication materials to involve patients more in their health check and to empower patients to be proactive at maintaining a healthy lifestyle.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the treatment and support of patients experiencing poor mental health. We saw how GPs had

supported patients in the community and in some cases this had meant patients had been able to stay in their home environment. Practice staff had worked with all stakeholders to reduce the number of 999 ambulance call-outs, to patients who did not fully understand the definition an emergency medical situation. All GPs and nursing staff showed a good understanding of legislation in place to protect a patient's right to choose how and where they could be treated and we saw how this was working in everyday situations that the GPs dealt with. The practice partners had worked with other surgeries to share resources and to bring counselling services to patients at the practice. We saw two outstanding examples of how this had helped patients recover from episodes of poor mental health.

Summary of findings

What people who use the service say

Before our inspection we arranged for CQC comment cards to be made available to patients at the practice to express their views. On the day of our inspection 31 cards had been completed. Of these, only one expressed a negative comment. All other comment cards described a service that was, in the patients' view, 'outstanding'. Comments were made particularly on the commitment of the GPs at the practice, the time given to patients in consultations and how GPs listened to patients. Patients also spoke of the encouragement they had received from GPs and nurses in taking ownership of their health and well-being. Patients commented that they were supported to do this, for example, by the practice being open at lunch times so patients could 'drop in' to have their weight and blood pressure checked, to encourage them with diet and exercise programmes.

Patients we spoke to on the day of our inspection commented on the trust and confidence they had in all clinicians and staff at the practice. Staff from one of the local residential care homes, visited the practice on our inspection day, specifically to speak to us about the care delivered to patients at the home. This had enabled patients to choose to stay at the care home when their health care needs changed, rather than be admitted to hospital. This had only been made possible by the support the home received from the practice GPs, nurses and the practice commitment to close working with the multi-disciplinary team in the community.

Data we reviewed showed the practice performed well in comparison to other practices in England. The practice scored highly in areas we have found to be important to patients. Data from the NHS England GP Patient Survey (2013) showed 86.2% of patients described the GP surgery as good or very good, compared to an England average of 85.7%. Those patients who said their GP was good or very good at involving them about decisions on their care, totalled 83.4%, compared to an England average of 81.8%. Patients described their GPs as being good or very good at treating them with care and concern – 91%, compared to an England average of 85.3%.

In areas that GP practices tend to achieve lower scores, this practice had done well. Particularly, 85.5% of patients said they could get through to the practice by the phone, compared to a positive national response of 75.4% of patients.

The practice is located in a semi-rural area. The partners had worked with neighbouring practices to secure more services for patients through the sharing of resources. This was particularly valued by patients at the practice who told us they would otherwise have to travel to Macclesfield, which by public transport, was a particularly lengthy journey.

Outstanding practice

We saw several areas of outstanding practice;

- Audits were targeted and carried out in response to data or reports on clinical findings. Examples we saw of completed audit cycles showed patient outcomes were improved; rates of hospital admissions from nursing and care homes dropped significantly and the length of any patient stay in hospital was also reduced.
- GPs had a clear vision and this was shared by all staff. The partners recognised that engagement with patients, beyond time spent in the consulting room was key in getting health initiatives off the ground. GP's encouraged families and young people to use technology to help make health and lifestyle decisions. Examples included use of applications on computers or smart phones to help calculate calorie intake, or the use of pedometers to measure the contribution community walks made to exercise needed each day. GP registrars on training placement with the practice were taught to 'view excellence as the norm rather than the exceptional'.
- The practice included **all** community stakeholders in their weekly practice meetings, for example community pharmacists and managers and carers

from the local domiciliary care agency. Evidence was available to demonstrate that this reduced the instance of more vulnerable patients being re-admitted to hospital care.

- GPs at the practice were committed to providing support to older patients who wished to remain at home rather than be admitted to hospital. Patients receiving palliative or end of life care were helped to make advanced decisions about their care and treatment, which were recorded. GPs were innovative in the use of technology to ensure those patients whose verbal skills were impaired by illness, could communicate their wishes.

The Schoolhouse Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice manager and an Expert by Experience. An Expert by Experience is a person who uses primary care services on a regular basis.

Background to The Schoolhouse Surgery

The Schoolhouse Surgery is located on the edge of Stockport, Cheshire. The practice is run by the three partners and a salaried GP.

The practice has two nurses, a healthcare assistant and phlebotomist.

The practice is a training practice and delivers services under a Primary Medical Services (PMS) contract. The practice register is made up of approximately 4,500 patients. The practice is based in an old schoolhouse which has been converted to provide treatment and consultation rooms on the ground floor which is wheelchair accessible. There are further treatment and consultation rooms on the first floor of the building. Parking is available immediately outside the building; parking for disabled patients is clearly marked. The doorway to the practice has push button opening for ease of access. The practice is open from 8.00am to 6.30pm Tuesday to Friday and offers extended hours surgeries on Monday of each week, from 8.00am to 8.30pm. Patients requiring services beyond these times are directed through the telephone service at the practice to an out of hours service from another provider.

The practice has an active Patient Participant Group (PPG) which has been in place since 2010. Regular updates from the group are posted on the practice website; a notice board for patient information on how to contact group members or find out dates of next meetings is prominently placed in the reception area of the practice.

The practice supports two residential care homes for elderly patients, two nursing homes for older patients, a residential facility for patients with learning disabilities and a residential educational facility for children not in mainstream education. The practice works with neighbouring practices to maximize resource and facilities. In doing this, it has been able to provide further services to all patients in the community, for example ultrasound scanning, audiology, physiotherapy, ophthalmology and counselling services. The PPG described the impact this had made; we were told that those patients who were in poor health, frail, or relied on public transport, found the journey to Macclesfield hospital particularly difficult and arduous, so the additional services where highly valued by the community.

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.

Detailed findings

How we carried out this inspection

Before our inspection we reviewed data from a number of sources, including information from Eastern Cheshire Clinical Commissioning Group (CCG) and results from Quality Outcome Framework (QOF) data. QOF is a system that GP practices use to record their clinical interventions with patients, for example, offering flu vaccination to patients over 65 years of age, antibiotic prescribing, or the percentage of patients with a diagnosis of a specific condition such as dementia or diabetes. We reviewed comments posted to the NHS Choices website about the practice, and information from the last National Patient Survey. We left CQC comment cards for patients to complete, to tell us about their experience of care at the surgery. On the day of our inspection, we were accompanied by an Expert by Experience, who spent time talking with patients and asking their opinion on the services delivered by the practice.

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)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

We inspected the practice on 4 December 2014. We reviewed management records, staffing and systems in place at the practice. We looked at the safety record of the practice and effectiveness of patient care. We considered how the practice responded to patient opinion and how well led the practice was. We observed how patients' were being cared for and talked with carers and/or family members.

Good

Are services safe?

Our findings

Safe track record

The practice is rated as good for the provision of safe care and treatment.

Mechanisms were in place to identify report, and record any safety incidents. The practice had an open, transparent culture where the focus was on learning from any incident. We saw from examples of significant event analysis that patient safety was always the priority of the practice. The GP partners told us how they considered the needs of any patient involved in incidents, and the importance of protecting patients' physical and mental well-being. Findings from investigations were shared with the wider healthcare community and where a patient had been involved GPs shared their findings with that patient. The design of the reporting and investigation process at the practice meant outcomes and findings could be probed and discussed which meant the culture of openness and transparency was upheld.

The practice managed complaint investigations in the same way as significant event analysis. As a result, any complaint, verbal or written, about care received was subject to the same level of scrutiny. This provided opportunities for learning for all staff, which was shared at regular practice meetings.

The practice had a whistleblowing policy which all staff, including trainee GPs were familiar with. Staff we spoke to were confident about how they could escalate any concerns and demonstrated their knowledge of who concerns must be reported to.

Learning and improvement from safety incidents

The practice provided several examples of how learning was shared following any significant events. Examples we reviewed showed that outcomes from investigations and the subsequent learning was shared not only internally but also with other practices and within the wider CCG area. This demonstrated that the practice recognised that learning should be shared within the wider profession. The practice was congratulated by the General Medical Council on recognising such opportunities and on the way it maintained patient confidentiality. The 'conclusion' section of significant event analysis reports, asked if there were any ideas that could be shared more widely, which could prevent similar incidents occurring. This was used to prompt discussion amongst practice staff and clinicians and provided another example of how the practice promoted openness and transparency. We saw how patient safety, health and well-being were the top priority of the practice. Learning from some incidents had prompted the practice partners to work more closely with other organisations and develop services in partnership with other practices for the benefit, safety, health and welfare of all its patients.

The practice had a reliable system in place to deal with Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. These were shared with all staff and remained on the staff meeting agenda as a permanent item, providing opportunities for further discussion. The practice also had a pharmacy technician who could discuss any change in treatment required for patients with GPs and nurses at the practice.

Reliable safety systems and processes including safeguarding

The practice had a system in place to support and review the work of trainee GPs on placement. Sufficient time was available between appointments for the trainee to speak to one of the partners about any queries or concerns. Trainees always knew which partner was responsible for supervising them during each surgery. Medical notes were also checked by the partners to ensure consultations were documented correctly, which reduced the risk of recording errors. The computer system which the GPs used for prescribing also had safety features built in, to highlight any possible risks of prescribing some medicines for patients. Practice computers had the CCG prescribing protocols immediately available to GPs, meaning best practice guidance and local updates for prescribing were followed. As a result of this, prescribing was closely monitored against budget and GPs could respond quickly to changes to treatment pathways, some of which were in response to MHRA alerts.

The practice had appointed a lead GP for safeguarding of children and vulnerable adults. All GPs had received safeguarding to the required level. All staff had received safeguarding training and this was refreshed every three years and supported by on-line training on an annual basis. When we asked GPs how many patients were subject to a safeguarding plan they were able to tell us immediately,

without checking records. When we made checks on this we found the information given by the GPs was correct and up to date. This confirmed that communication in the practice on safeguarding matters was effective.

A chaperone policy was in place at the practice and this was advertised to patients in the reception area. Nurses would be the first staff to be called on to provide this service. If nurses were not available, other practice staff had received chaperone training. We saw from staff files that risk assessments had been carried out for non-clinical staff performing these duties. As a result, all staff had the appropriate background checks in place which indicated that they would not be unsuitable for these duties.

Medicines management

The practice had systems in place to manage the safe prescribing of medicines. All treatment followed best practice guidance. Patients who received regular repeat medicines had their condition reviewed regularly by either a GP or a practice nurse. Nurses we spoke with told us how they would follow-up on patients, if staff reported that repeat prescriptions for medicines had not been collected. Nurses used the opportunity when contacting patients, to provide assurance to clinicians that medicines were being taken as prescribed.

Practice nurses had received training on the delivery, safe storage and stock-rotation of vaccines. Members of administrative support staff had also received this training and could cover this duty if a nurse was not available. We saw that all medicines and vaccines were safely stored. Fridges for storing vaccines were temperature controlled. Regular checks on the reading of temperatures were in place. Staff were able to refer to the cold chain policy in place at the practice. A cold chain policy gives guidance on how medicines requiring storage in refrigerated conditions should be kept and handled.

We checked emergency medicines kept at the practice. We saw that these were in date and ready for use. Medicines kept for use in an emergency were securely stored but accessible to all staff.

Cleanliness and infection control

The lead nurse at the practice was responsible for the monitoring and management of infection control. A recently recruited nurse was able to show us the infection control policy for the practice, which was developed in line with guidance from the Royal College of General Practitioners (RCGP) and Community Infection Control Nurses Network. We saw that updates and guidance from Eastern Cheshire NHS Infection Control had been reviewed and added to guidance for staff. Infection control was also a regular agenda item at practice meetings. This provided an opportunity for updates to be shared and discussed. The practice had an infection control inspection checklist in place. An audit of these checks was carried out in August 2014 which showed the practice to have effective procedures in place.

We conducted a visual inspection of the building; we found all areas to be clean, tidy and consulting and treatment rooms were clear of any clutter. Cleaning schedules were in place and regular checks on standards of cleanliness were carried out by the practice manager. Contracts were in place for the safe disposal of clinical waste and sharps bins. The practice had disposable personal protective equipment in place in all treatment rooms, including masks, aprons and gloves. Spillage kits were available for dealing safely with spills of bodily fluids.

Equipment

The practice nurses were able to show us that all equipment was subject to regular safety testing and calibration. All portable appliances carried stickers showing when the next test was due. From records we checked, we saw a full inventory of equipment was held, which detailed the equipment kept in each room of the practice. The log detailed the name and contact details of the maintenance contractor, the date of last safety checks and results of calibration testing. The nurses provided spirometry services and took a calibration reading from the machine used for this, before using on a patient. Spirometry is the measurement of how much air a patient can breathe in and out.

The practice carried oxygen for use in an emergency and we saw that this had been checked for safety in use. The practice also had a defibrillator

The practice used single use disposable items for patient treatment, such as syringes for injections or tubes for use with peak flow meter testing. We saw that stocks of equipment were sufficient and stored in date order where necessary.

Good

Are services safe?

We noted that one of the partner GPs had an old style, mercury blood pressure gauge. This had also been recently tested and calibrated. The practice had mercury spill kits to use if this gauge was damaged resulting in the escape of mercury.

Staffing and recruitment

The practice had recruitment checks in place to ensure that staff working at the practice were sufficiently skilled and suitable for work with vulnerable patients and confidential patient information. When checking staff recruitment records, we looked at the file for a recently recruited nurse and a member of administrative support staff. The practice manager had taken up references from previous employers, conducted background checks with the Disclosure and Barring Service (DBS) and held copies of two primary forms of identification for each staff member, such as driving licences and passports. The skill mix of staff was sufficient to meet the needs of the practice. We were shown how the practice was planning in advance, to safely meet the needs of patients when the senior partner of the practice retired. The partners had considered the skills set required to continue as a training practice, and recruitment planning had addressed this.

Monitoring safety and responding to risk

The practice had systems, in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were familiar with. This was covered as part of the staff induction and formed part of the training refresher delivered to all staff annually.

GPs and nurses at the practice contributed to the monitoring of safety of patients who were receiving care and treatment at home or in a home setting. All information was shared at multi-disciplinary team meetings. The practice was committed to meeting the wishes of those patients who wished to remain in their home, and staff risk assessed the viability of this, working with other stakeholders, such as the community pharmacists and local care provider agency.

Arrangements to deal with emergencies and major incidents

The practice had plans in place to deal with emergencies, in terms of patient care and in terms of business continuity. The partners of the practice lived relatively close by, but the location of the surgery meant that each partner had made an assessment on how they would get to the surgery in bad weather, and how the journey could be safely made. The ability of staff who worked at the practice to get to work in severe weather was also considered; we found that cross training of staff with key duties was a feature at the practice.

A business continuity plan was in place and copies of this were also kept outside of the surgery, for example by the partners and practice manager.

We checked emergency medicines kept at the practice. We saw that these were in date and ready for use. Medicines kept for use in an emergency were securely stored but accessible to all staff.

The practice had planned and delivered flu vaccination clinics over a weekend in October to capture all eligible patients and reduce impact on availability of patient appointments during normal surgery hours. The practice was advertising widely, the availability of vaccination against shingles, which can impact severely on the health of older patients. The practice manager told us uptake of this had been good, which contributed to the welfare of older and more vulnerable patients.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice is rated as outstanding for the provision of effective care and treatment.

The practice delivered evidence based care and treatment and followed the latest published best practice guidance. GPs and practice nurses met with all stakeholders at multi-disciplinary team (MDT) meetings, held at the practice on a weekly basis. Stakeholders included health visitors, district nurses, physiotherapists, local community pharmacists and the manager and carers from the local domiciliary care agency. The team worked together to ensure that care plans were designed to meet the individual needs of patients. When any patient was discharged from hospital, checks were made that all support services were in place and any new medicines required were available to patients. The practice was able to demonstrate how this approach had reduced re-admission to hospital of vulnerable patients. When GPs visited patients at home, they checked that the care plan continued to meet the needs of the patient. Where this was not the case, the community team were informed and advised of what more was required. The care plan was reviewed and updated at the next weekly MDT meeting. In one example we saw how this approach had produced much improved results for a patient who had experienced eight hospital admissions in a 12 month period, with multiple out-of-hours call outs. More recently, this patient had experienced just one hospital admission and was being successfully and safely treated at home, which was in accordance with their wishes.

Management, monitoring and improving outcomes for people

The practice supported two local nursing homes and two residential care homes. One of the homes provided residential care and accommodated patients with dementia. The practice had worked with the homes to reduce hospital admissions and to help people remain at the homes, even as their health condition became more complex. The GPs had achieved this through monitoring risks to patients during regular 'ward rounds' at the nursing homes. As care and treatment provided was proactive rather than responding to frequent call-outs, better monitoring of patients medical conditions was in place and risks to patient welfare were reduced. One of the practice partners had presented findings to Eastern Cheshire Clinical Commissioning Group on the effects of implementation of a GP led enhanced service to a nursing home. The enhanced service consisted of a proactive, GP 'ward round' once a week at the home. An audit of three, six month periods was conducted to see what effect the enhanced service had on hospital admissions. Results showed that hospital admissions fell from 28% of patients, to 8.8% of patients. Further, the length of hospital stay was shorter for each patient, falling from approximately nine days per patient to approximately 5 days per patient.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audit we reviewed included an audit on the effectiveness of annual health checks for patients with learning disabilities. The audit was conducted in response to updated guidance from the RCGP. The aims of the audit were clearly defined; that patients with learning disabilities get equal access to health care in a timely manner; that health checks were used to identify and treat any medical conditions early; to screen for syndrome specific conditions; and to improve health promotion for this population group.

As a result of the audit two significant changes were made. Firstly, the health check given annually to patients in this population group was far more detailed and patients were screened for many other health conditions. Where other health conditions were identified, patients were added to the appropriate disease register. For example, a practice register for patients with diabetes. Secondly, the rate of attendance of patients for health check appointments was interrogated. It was found that some patients could not attend the surgery, so were visited at home to have the health check. A new 'easy read' appointment letter, giving information in simple wording and pictures was used to communicate directly with patients. By using the audit to identify changes required in delivery of this service, the practice had achieved health checks on 100% of its learning disability patients.

The practice had considered the treatment of patients by out of hours GPs and how access to the most up to date information on patients could be improved. As a result, the care homes supported by the practice were given copies of patients' blood test results, to keep with care records. The practice had re-visited all patient records to improve and tighten read coding, so patient summary notes were richer in detail for out of hours GPs. All patients on end of life care

had a checklist document in place to ensure all community clinicians could access their notes. When we spoke with staff from one of the care homes supported by the practice, they told us how out of hours services had commented on the quality of information available to them when visiting a patient at the home. We were told how the healthcare needs of several patients at the home had increased significantly, and how the level of support they received from the GPs at the practice had enabled them to stay there, rather than be transferred to a nursing home or hospital.

Effective staffing

All staff at the practice completed a training needs analysis form annually. This enabled the practice to identify gaps in training and to maintain an effective skills mix amongst all staff. We saw how staff had been identified for further skills development. Examples included administrative staff training to take the lead on IT support and development at the practice, and an administrative member of staff training to do phlebotomy work. All staff were engaged in the development of their skills and told us this increased their commitment to the practice. All staff were given protected learning time.

A recently recruited practice nurse told us they had received an 'excellent induction' to the practice. They explained how the practice had developed a comprehensive training plan, with regular feedback and review of work carried out to provide assurances that training delivered was effective. The practice had utilized support from other practices to deliver this; one example was the support of a nurse at a neighbouring practice, whose specialist area was the management of patients with diabetes.

We found that GP registrars at the practice were well supported by the partners and staff. A registrar we spoke with told us they had access to a mentor at all times and that they were given sufficient time with one of the partners to discuss patients with more complex needs if required.

Working with colleagues and other services

The practices worked closely with three other practices nearby, sharing resource to improve patient outcomes and to make more services available and accessible to patients. Examples of results achieved included the provision of audiology and ophthalmic services to patients. The practices shared a pharmacy technician and care co-ordinators, who helped manage the safe return home of vulnerable patients from hospital.

The practice viewed all stakeholders in the community as integral to the success of safe, effective patient care and treatment. As an example, the manager of the local domiciliary care agency and community pharmacists were invited to multi-disciplinary team meetings held weekly at the practice. The practice was able to demonstrate how this had improved outcomes for patients and had reduced the risk of patients being re-admitted to hospital.

The practice regularly invited guest speakers to their staff meetings. Often these would be to increase awareness of other services that were available which patients could be referred to by any member of staff.

Information sharing

We reviewed systems in place for referral of patients to secondary care for consultations with specialists. We saw that this process was well-managed; a template was used by secretaries at the practice to transfer all relevant patient information to hospital specialists. The templates contained links to pertinent parts of patient records, for example, records of blood test results, or of previous referrals to specialists. We could see from random checks conducted that patients' treatment was not delayed due to incomplete information from the practice.

The practice held registers of patients receiving end of life care. These were updated and shared with out of hours services. District Nurses and community physiotherapists were able to access electronic patient records when working in the community.

Consent to care and treatment

All staff at the practice demonstrated a good understanding of The Mental Capacity Act 2005, the Children Acts 1989 and 2004, Gillick competency and the importance of informed consent. We were given a number of examples of this. Two particular examples were outstanding; the practice had worked with several patients to help them make significant decisions about their care and treatment. For some, the decisions they made meant that as a disease progressed, they would not be able to take food and drink themselves, but could be fed by tube if they wished. If the decision was not to be tube fed, GPs explained that this may prove irreversible, should they

change their mind. Each patients' record held evidence of a mental capacity assessment, the offer of support from an advocate and where appropriate, discussion of decisions with family members. All clinicians involved in the care and treatment of the patient were made aware of the wishes of the patient.

The practice had also provided support to families and carers, to help improve their understanding of consent issues.

Feedback from patients following bereavement had suggested they had not been made aware of their family member's wishes to die at home. Significant numbers of patients had expressed a wish to be cared for within the home rather than be admitted to hospital at end of life. Often this had not been documented or family and carers were not aware of decisions made by the patient, as they had not been involved in care planning. Research conducted by the practice showed that in 2010, 60% of patients had been admitted to hospital at end of life. The practice responded by ensuring patients who expressed a wish to be at home at end of life had this documented in care plans. The care plan was available to all clinicians involved in end of life care, which ensured patients' wishes were recorded and respected. By 2013 the number of patients admitted to hospital at end of life had dropped to 17%. The practice accepted that there could be other factors involved in this reduction in numbers but pointed to the use of the feedback making a positive difference to some patients, their carers and families.

Health promotion and prevention

The practice had patient information leaflets available in reception and waiting areas. These contained a number of information leaflets details of various healthcare initiatives, for example, health walks organised in the local area. Information was available on all services provided by the practice, and how these could be accessed.

The practice shared the services of a nurse whose special area of interest was diabetes care and management. Educational sessions for the GPs and practice nurses had been delivered by this nurse and any updates on treatment and best practice could be explained and discussed with the clinical team to ensure patients received the best possible outcomes.

The practice nurses delivered a range of disease and condition management clinics. Nurses were available at extended hours' surgeries to see patients who required an appointment. Nurses would also make themselves available at lunch times if they were needed. Work had recently started at the practice to encourage people to lead healthier lifestyles. We observed how the practice supported patients to do this; rather than tell them what they should do, they showed patients how it could be done and supported them on their road to particular health goals, for example weight loss and increased exercise. Patients were encouraged to 'drop in' to see a nurse who would weigh them and/or check their blood pressure, so patients were able to appreciate the results that they had brought about themselves by taking ownership of their health and well-being.

The practice offered a range of enhanced services, for example Meningitis C student vaccinations and childhood flu vaccinations. The practice offered measles mumps and rubella (MMR) catch-up vaccination programmes for those children and younger people who had not received the vaccine as a baby. The availability of nurses through lunchtimes and extended hours contributed to the take-up rate of these services.

The practice clinical team had been nominated for, and was a finalist in the national General Practice Awards 2014, for its work with patients with long term conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice is rated as good for the provision of caring services.

An Expert by Experience visited the practice with us on the day of our inspection to support us by carrying out patient interviews. All patients interviewed spoke of the outstanding level of care they received from the GPs and nurses at the practice. Patients particularly commented on how compassionate the nurses and GPs were. Patients told us that all staff treated them with respect. Whilst we were at the practice, we saw how staff would greet people by name. Staff had a rapport with patients that was friendly and professional.

Staff who worked at a local care home that the GPs supported, contacted us to share their views on the service provided to patients at the home. We were told how one of the partners would call staff in the evening to check on how a patient was, following a visit to the home by the GP earlier in the day. We were told how, over a number of years, the GPs and nurses had worked to support patients at the home, which allowed them to stay there as their health condition became more complex. Staff described how patients at the home with no close family relations, had built friendships with other patients and how moving out of the home could have been distressing for some patients. The staff we spoke with told us patients' wishes were respected and said they valued the services provided by the practice.

Care planning and involvement in decisions about care and treatment

We saw that the practice involved patients and when appropriate their carers, in the planning of any care and treatment. We saw several examples of outstanding care and patient involvement, where patient choice in how they were treated, where and by whom was respected. Risk assessments were carried out to protect patients from any environmental risks and potential clinical risk. In one example we saw how GPs had used an I-Pad to help a patient communicate their wishes and incorporate these in their care plan. Access to the care plan was made available to District Nurses and other care providers within the community. The practice had reviewed their communications with patients who had a learning disability; paper communication was made more relevant and user friendly, for example by using terms of reference that were current amongst patients with learning disabilities.

Patient/carer support to cope emotionally with care and treatment

The practice kept a register of all patients who were carers for family members. Some patients interviewed on the day of our inspection told us how they had been supported by the practice staff following bereavement. Administrative support staff we spoke to told us how they would raise a concern with the GPs if a patient who was also a carer missed an appointment or had not collected their own medicines. Staff showed a high level of awareness of the impact on carers, of caring for a family member.

The practice worked closely with the local carers centre, which provided carer support. The practice healthcare assistant acted as a link to this service for referral of any patients.

Data we reviewed showed the practice scored highly in areas we have found to be important to patients. Data from the NHS England GP Patient Survey (2013) showed 86.2% of patients described the GP surgery as good or very good, compared to an England average of 85.7%. Those patients who said their GP was good or very good at involving them about decisions on their care, totalled 83.4%, compared to an England average of 81.8%. Patients described their GPs as being good or very good at treating them with care and concern – 91%, compared to an England average of 85.3%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice is rated as good for the provision of responsive services.

The practice GPs showed us how a second example of how they had responded to a significant rise in call-outs to a local nursing home. Data was gathered and used to determine the nature of the call-outs and the impact on GP availability. We were shown how this had reached a peak when there were 105 call-outs for acute care in the three month period from May to July 2011. The practice made a provision for regular ward rounds for the home and developed key contacts amongst the nursing staff. For the same three month period in 2012, the number of call outs fell to 28, and by 2013 the number of call-outs for the same three month period fell to just 19. This represented an 80% reduction in call-outs for acute care. The impact of this was greater GP availability for other appointments at the practice

The practice shared resources with neighbouring practices, to provide more services for patients. This joint working had resulted in the practice being able to offer a much wider range of services including those of a specialist diabetic nurse, ultrasound scanning, counselling services ophthalmology and audiology and podiatry services. The practice also shared the services of a hospital discharge co-ordinator and a pharmacy technician.

Tackling inequity and promoting equality

The practice supported a residential facility for patients with a learning disability. The practice had used updated guidance from the Royal College of General Practitioners (RCGP) to improve health checks offered to this patient group and to increase the number of clinical interventions. This provided more opportunity to support patients physical and mental well-being. For example, more screening was introduced for syndrome specific conditions. Patients were placed on disease registers if diagnosed with a chronic condition, for example, for diabetes. This meant regular health checks would be required to manage this condition, which increased opportunistic checks for other health problems.

The practice had access to Language Line, to provide interpreting services if and when needed. Staffs told us they currently had no patients who did not speak English, but where aware of resources they could use should the need arise. We asked about services to assist those patients with hearing difficulties. Staff told us they had all attended a deafness awareness course; again, there were no instances that staff could recall where they had been required to use a hearing loop system, or provide a staff member who could use sign language. One of the GP partners was aware of patients with learning a disability, who were also deaf, but these patients used a form of sign language called Makaton, and their carers always attended the surgery with them.

Access to the service

Patients we spoke to on the day of our inspection told us access to GP appointments was good. We were told that there was a slightly longer waiting time if patients had asked to be seen by a specific GP.

The practice demonstrated how it had used information from the National Patient Survey, as a guide for issues to probe further with its own practice survey. This was developed with input from the Patient Participant Group (PPG), and from comments and suggestions made by patients. The results were used to plan, improve and develop services further. Findings from these sources were discussed at practice meetings. One example we saw was how the staff were given the autonomy to implement a responsive lunchtime surgery, where they saw this was needed. This idea had been tested and worked well. Appointments could be face to face or by telephone; nurses could also be asked to see patients in this surgery. This had increased access to GPs for people who worked during the regular surgery hours of opening.

The practice met the requirements of the Equality Act 2010; access to the building for patients who used walking aids or a wheelchair had been considered. There was a push button to open the entry door to the practice. Consideration had also been given to parking facilities, as the forecourt of the practice was cobbled and subject to listed building status. The practice had overcome this by having designated disabled parking spaces close to the door, and the cobbled area had been grouted to provide a smooth surface for the safe use of walking frames and wheelchairs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

The practice recorded and responded to all complaints whether formal or informal, written or verbal. We reviewed some complaints received; the practice manager showed us written responses to verbal complaints. These acknowledged any frustration expressed by the patient, and thanked them for the feedback, commenting that the practice will always learn from patient feedback, positive or negative.

The practice used feedback from patients and the PPG to identify services that could be made available at the practice through the sharing of resource with other practices nearby. Patients we spoke with were particularly appreciative of these additional services.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

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

There was a clear vision and strategy for the delivery of high quality, safe and effective care and treatment. All staff showed their commitment to the values of the practice. The Statement of Purpose of the practice set out its commitment to providing the best care and treatment to patients; "The practice aims to exceed patients expectations through high standards of work and excellent clinical care and judgement."

The practice had developed its strategy to meet the changing nature of primary care services for patients. The partners had increased joint working with other practices in the area to make more services available to their patients. The practice had maintained its own identity, which the partners recognised was important to patients. In the recruitment of staff, the partners recognised that customer service was key to its success. To achieve this, the partners recruited a practice manager with a strong customer service background, taking the view that the person had to be right for the practice, and that other duties could be learnt.

The partners held a business meeting once a month and had recently attended a brainstorming meeting with the partners of other practices they shared resources with. This was to explore ideas and thoughts on how services could be developed over time.

Governance arrangements

The practice had effective governance systems to support the safe running of the practice. All staff were clear on their responsibilities and clear lines of accountability were in place.

The system of clinical audit in place was used to identify areas for improvement, both clinical and for support services. We saw how nurses and GPs used benchmarking of patients' outcomes to ensure that treatments prescribed delivered the best possible outcomes for patients.

Risk assessments were in place for any lone working, for example, on extended hours surgeries. All staff completed a skills and training need analysis each year, which was used to identify training needs and develop staff to ensure there were no single points of dependency, for example, by not having limited numbers of staff who were trained in clinical coding. The governance arrangements in place were designed to support the practice as it grew, in the number of services it provided as well as in the number of patients it serves.

Leadership, openness and transparency

Leadership at the practice was provided by all partners and the practice manager. The practice was a training practice. The GP registrar on placement at the time of our inspection told us leaders were accessible and provided high quality support and guidance. Leaders were aware of staff needs and made any adjustments required to make a staff member welcome. One example was that of a GP registrar on placement with the practice who required a prayer room for religious observances. This was organised quickly by the partners.

The practice partners told us of a serious incident that had been reported by the practice. The practice was able to demonstrate it had an effective system in place for managing any clinical performance issues.

The recently recruited nurse at the practice spoke of the quality of leadership and support received. Arrangements were made to provide access to a mentor; a comprehensive induction was offered when starting work at the practice. We saw that staff learning and development plans had been reviewed and updated on a regular basis. We were told how the practice encouraged learning and development. Staff confirmed there were regular meetings at the practice and staff were encouraged to add any item they wished to discuss, to the meeting agenda.

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

The practice used a number of ways to gather patient feedback. A suggestions box was prominently placed in the reception area. The complaints policy was available to patients and all complaints, verbal or written were responded to and recorded. The practice reviewed findings from the National Patient Survey, as well as the survey developed with the help of the Patient Participant Group (PPG), to identify areas for improvement. This helped the practice partners focus on issues patients experienced, for example those patients reliant on public transport to access services only available from the local hospital. This has led to some improvements in services, for example availability of a patient scanner at the practice.

Are services well-led?

Outstanding ☆

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

Staff confirmed they had regular, quarterly practice meetings with the practice manager to discuss any issues relating to the running of the practice. For example, where extra duties had been added to a staff members role and how well this was working. Job descriptions were updated at least annually and staff said they fed back to the practice manager if they found time constraints meant they were not able to fulfil all duties assigned to them.

Management lead through learning and improvement

All staff had individual and team objectives. All staff received an annual appraisal and periodic review of their objectives, for example, following a learning event. We saw there were strong support mechanisms for the GP registrar, who told us the standard of leadership and support was very high. The registrar GP on placement at the time of our inspection, was a fan of amateur dramatics and was encouraged to use this in role play scenarios with the partners as a tool to facilitate learning.

The practice had a very low staff turnover. Succession planning was in place and consideration was being given on how the practice would recruit a GP to take on some of the duties of the lead partner, who was due to retire at the end of the year.

Practice partners recognised that engagement with patients, beyond time spent in the consulting room was key to leading patients to better health and improved lifestyle choices. The partners had recently taken a CCG initiative to encourage walking, to a personalised and community level. Partners and practice staff had led community walks, encouraging patients and their families, friends and pets, to join in. This initiative was being further advanced, involving other stakeholders, such as the parish council and some well-known local celebrities to encourage uptake. Initial results had been very positive; at the time of our inspection, the practice was helping patients to use pedometers to calculate their level of activity. One of the partners described ambitions to use this initiative to engage with younger patients and families at the earliest possible opportunity, by utilising children's natural affinity for learning with the use of technology, a feature of the initiative. For example, using phone applications (apps) to measure sleep quality and calorie count. For adult patients, walk in blood pressure testing and weight loss recording was be made available in 'drop in' sessions with nurses during lunch times. The partners had truly engaged with the PPG to spread the word on this initiative, and many of their ideas had been incorporated into the initiative.