Oakwood Medical Centre

Quality Report

Broadway
Barnton
Northwich
Cheshire CW8 4LF
Tel: 01606 544241
Website: www.oakwoodmedicalcentrebarnton.co.uk

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

Ratings

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Oakwood Medical Centre on 25 June 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- The practice had clearly defined governance systems that promoted patient safety. One example was the way in which the practice recorded all patient interactions, requests, queries, messages and responses to these on the electronic patient record system, giving an auditable trail for review.
- Clinical audit drove improvement. All staff were engaged in continuous improvement through training. Both the practice manager and the patient services supervisor had studied Productive General Practice through the NHS Institute of Innovation and Improvement. Learning from this had been applied within the practice.
- The way in which the practice engaged with patients helped patients take ownership of their healthcare needs. Patients told us they received high quality care that was compassionate and met their needs.
- The practice was able to demonstrate that they were truly responsive to patients' needs. Plans to host services in the practice reflected the demand for those services. For example, community mental health team services, counselling services.
- The practice was well-led. Leaders worked to analyse and forecast patient demand and contracted services accordingly. This included the use of an intermediary care bed service, where patients could receive support between leaving hospital and returning home. Figures showed this service was well-used helping prevent hospital admission and reducing the length of time a patient would typically spend on a hospital ward.

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 used every opportunity to learn from internal and external incidents, to support improvement. All staff understood their duty to raise and report any concerns. Strong governance systems meant risk was assessed and reviewed over time. The practice had implemented an urgent messaging system for reception staff to use if a patient's condition deteriorated rapidly and needed to see a GP urgently, for example, acutely ill children. All staff employed were qualified and sufficiently experienced to ensure patients safety.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Audit drove improvements in patient care and treatment. Audits undertaken were reviewed to check that processes were strong enough to ensure accurate results. The results of audits were shared between the practice teams and more widely, if it was thought that outcomes could offer insight to other practices.

Are services caring?

Good

The practice is rated as good for providing caring services. We received 18 CQC comment cards which patients had used to share their views on the service. All cards contained positive comments. Patients had also included some negative comments around the ability of patients to get through to the practice by phone, at peak times of the day. When we spoke with patients, they told us they received a good service from GPs and nurses. Patients who were parents told us they were able to see a GP with their sick child on the same day if this was needed. Patients told us they valued the 'sit and wait' clinic.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. GPs had lead areas of knowledge and responsibility and referred patients to their colleagues within the practice to provide some diagnoses, for example, in response to concerns about skin lesions. We saw how the practice had responded quickly to a surge in cases of childhood Scarlet Fever, briefing staff on signs to look for and working with Public Health England to record, treat and follow-up these cases. The practice had responded to patient feedback which had been collected over two, three month periods. It used this data

Summary of findings

to design extended hours services, using funding from the Prime Ministers Challenge Fund, which is available to increase access to primary medical services. As a result of this the practice was able to offer an extra 2000 patient appointments per year and 700 additional telephone consultations per year.

Are services well-led?

Good

The practice is rated as good for providing well-led services. All staff responded well to the leaders in the practice and said they felt confident that they offered patients a very good service. The practice GP's were all partners; cover for any of the GPs was provided by the partners rather than by use of locums. The partners planned to expand the number of services available to patients, utilizing every free room at the practice. Local planning information and demographic data was used to inform recruitment and practice development decisions. For example, the partners had factored into development planning that 4,000 homes were being built in the area which could translate into 10,000 extra patients. The practice recognised this could mean approximately 15% of those patients registering with their practice; capacity planning, partnership working, recruitment and training of staff reflected this.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. One of the partners led the practice on care of older patients. We saw how risk profiling was used to identify older patients vulnerable to unplanned hospital admission. The care plans produced for these patients were reviewed regularly by the lead GP, for example on receipt of blood test results. This included the GP liaising with care homes involved in the care of some patients, to ensure updates were shared. Cognition testing was in place for older patients, who could be referred to a memory clinic if required. We saw how any patients identified in hospital as having some cognitive impairment, were quickly reviewed by GPs and referred onwards.

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. The practice clinicians met for 20 minutes each morning to discuss any patients that were particularly unwell or had been discharged from hospital. We saw that arrangements in place provided a good degree of clinical oversight and support for nurses managing patients with multiple long term conditions. For example, any patients with two higher than expected blood pressure readings were seen by a GP. A prescribing team who generated repeat prescriptions were able to send queries to GPs electronically, highlighting those patients who may need advice on compliance with medication regimes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Strong governance processes enabled the management of any children subject to a safeguarding plan. A further register was kept of those children categorised as a child in need or a looked after child. All requests for reports from GPs on these children had been met, and had been completed in the format requested by safeguarding review boards. The practice had offered to host these panels to increase the opportunities for attendance of GPs from the practice and locally. The practice performed well in the delivery of vaccines and immunisations to children and young people. Young people were treated in an

Summary of findings

age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school/college hours and access to nurse led advice clinics on contraception and sexual health was good.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people including those recently retired and students. The practice had analysed typical patient consultation times at the 'sit and wait' or open access clinics. From results the decision was taken to make each open access appointment seven minutes in duration. The rationale for this decision could be clearly explained and the number of open access slots available to patients was maximised. Patients we spoke with told us their access to GPs at the practice was good and that seeing a GP on the day they needed to was achievable.

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. All patients that were vulnerable were offered longer appointments, and with a named GP if this was appropriate. The practice served patients that lived in rural locations. We saw that those patients with higher dependencies were highlighted and that sufficient time was set aside each day for a GP to conduct home visits if these were needed. Some practice staff had been highlighted for training in a form of sign language commonly used by a number of vulnerable patient groups, for example patients with learning disabilities who were also deaf. The practice identified patients requiring support from other health care partners For example, the practice had been one of the highest referring GP practices to a support service for victims of domestic violence.

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 and those living with dementia. The practice hosted a number of services, including staff from the community mental health team, counselling services, and a link worker for carers of patients living with dementia. A partner at the practice was the lead on care for patients in this group and staff would always try to offer an appointment with this GP or with a GP the patient felt most comfortable with .

Summary of findings

What people who use the service say

We received 18 completed Care Quality Commission (CQC) comment cards, used by patients to express their views on the services provided by the practice. All comments were positive overall. Two cards contained comments on how it was difficult to get through to the practice by phone, especially at peak times in the day, for example at 8.30am each morning.

We spoke with six patients on the day of our inspection. Patients told us staff were dedicated, professional and always willing to listen. Patients commented on how well run and organised the practice was and appreciated the facilities and services made available to them at the practice premises. Patients particularly valued the 'sit and wait' or open access appointments. We spoke with three members of the practice Patient Participant Group (PPG). They told us GPs and staff valued their opinions and feedback. The older members of the group commented that staff recognised their 'experience through age' and were careful to deliver improvements that older patients would understand and could benefit from. For example, we were told how staff where available on the day that patient confirmation of arrival was introduced, to help people learn how to use this facility. Staff also explained to all patients what access to summary care records involved, what the potential benefits would be, and ensured that all patients understood what it was they were agreeing to.

Results from the last NHS England GP Patient Survey showed the practice performance in terms of patient satisfaction, was in line with other practices locally and nationally. For example, of those patients asked, 89% said the last appointment they got was convenient. The average score locally for this question was 91% and the national average score was 92%. Of those patients asked, 84% said they were able to get an appointment to see or speak to someone the last time they tried. The average local score for this question was 82%, and the average national score was 85%. Of those patients asked, 88% said the last GP they saw or spoke to was good at giving them enough time. The average score locally for this question was 84% and nationally 87%. Another area where the practice performed well, which patients say they particularly valued was with regard to GPs listening to their concerns. Of those patients asked 90% said the last GP they saw or spoke to was good at listening to them. The average score locally for this was 88% and nationally 89%.

Feedback from patients on the day of our inspection reflected the findings of the NHS England GP Patient Survey. Staff at the practice told us they enjoyed their work, and that patients appreciated efforts they made to make their visit to the surgery as stress free as possible.

Oakwood Medical Centre

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 Specialist Adviser and a Practice Manager Specialist Advisor.

Background to Oakwood Medical Centre

Oakwood Medical Centre is located in Barnton, Northwich, Cheshire. The practice falls within the Vale Royal Clinical Commissioning Group (CCG) and is run by five GP partners. Services are delivered under a General Medical Services (GMS) contract. The practice is registered with the Care Quality Commission as a partnership, to deliver the regulated activities, diagnostic and screening procedures; treatment of disease, disorder or injury; maternity and midwifery services; family planning; surgical procedures.

The practice serves approximately 8,300 patients and covers a large geographical area due to its rural location. The practice list has increased by approximately 30% in recent years. The practice partners expected this to rise again due to the increase in new homes in the area.

In addition to the five GP partners, two nurses, a practice manager, a health care assistant, a patient services supervisor and a team of 8 receptionist and administrative staff were also employed by the practice. The practice is located in a purpose built facility, which it shares with other community health services. Patients report to one reception desk which is covered by staff from Oakwood Medical Centre. All treatment and consulting rooms are at ground floor level, with meeting rooms and offices located on the first floor.

Opening hours are between 8.00am and 8.30pm on Monday of each week, and from 8.00am to 6.30pm Tuesday to Friday each week. The practice has used funding from the Prime Ministers Challenge Fund, to offer more extended hours appointments. These appointments with a practice nurse are available on Tuesday mornings from 7.00am – 8.00am. Availability of more late evening appointments has been increased within the existing extended hours surgery on Monday evenings. The practice now has two further GPs working in this period, creating 16 additional GP appointments. These are complemented by nurse led clinics. It is calculated that this funding will provide an extra 2,000 appointment per year and a further 700 telephone consultations per year.

Appointments can be booked on-line, by phone or in person. There are telephone consultations available each day. GPs offer home visits to those patients with higher dependency needs who would not be able to visit the surgery themselves. Out of hours services are provided by East Cheshire NHS Trust. Patient calls to Oakwood Medical Centre are diverted to the service when the practice is 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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 June 2015. During our visit we spoke with a range of staff including three GP partners, the practice manager, the patient services supervisor and a practice nurse. We also spent time talking to the Patient Participation Group and six patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. The staff we spoke with where aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice clinicians had put together some examples of first line physical indicators of serious illness that reception staff could identify and use to prioritise patients or to alert GPs to immediately. Examples included patients becoming drowsy, disorientated, confused or agitated. Leaders also ensured that staff had a high level of awareness of their own and colleagues safety, for example, if using a room away from the main reception to offer patients more privacy. Colleagues were encouraged to check that any staff member using a side room to talk to a patient was checked on.

Systems were in place to receive, share and discuss updates on safety alerts, for example, from the Medicines and Healthcare Products Regulatory Agency, and from Public Health England. Minutes of meetings held by the practice confirmed that this was a standing item on the agenda for a number of practice meetings, for example, clinical meetings and practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed a log kept by the practice manager of all significant events, choosing three at random to look at in detail. From these we could see that each event was investigated thoroughly and findings were recorded and shared appropriately. Where any incident involved a patient, they were advised of the outcome of the investigation. The practice was able to demonstrate that they learned from findings of investigations into significant events. For example, we reviewed an incident where a home visit to a patient was missed. The findings of the investigation showed that the request had come in later in the day and that the details of the request had been taken on paper. Following investigation, the decision was made that all incoming requests must recorded on the practice computer system. This would then generate requests as a task which is assigned to a GP or nurse. All home visits are now coded, which promotes a system of checking for administrative staff, to ensure the request has been reviewed by a clinician. The logging of any requests from patients, whether it be for a call back from a GP or for a home visit, on the practice computer system also provided an audit trail and promoted safe handling of information.

The practice reviewed significant events annually, checking for any emerging trends or patterns. Staff said they were supported when reporting any incidents and that a 'no blame' culture encouraged honesty, openness and learning from events.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs were trained to Level 3, nurses to Level 2 and administrative staff to Level 1. All staff had received updates and refresher training on safeguarding within the last 12 months. Staff knew how to recognise signs of abuse in vulnerable adults, including older people, and children. They were also aware of their responsibilities to report concerns. We saw that instructions and flow charts on when and whom to report concerns to, were clearly displayed in all staff areas of the practice including reception areas, administrative offices and the staff room.

One of the GP partners was the practice lead on safeguarding. Deputising arrangements were in place to cover any period of leave. All staff we spoke with where aware of who these leads were and who to speak with at the practice if they had a safeguarding concern. Particularly, we saw good communication between practice staff, health visitors and community midwives. For example, in relation to parents who failed to bring children to planned GP appointments, immunisation and vaccination appointments, and milestone child health assessments.

There was a system to highlight vulnerable patients on the practice's electronic records. A safeguarding register was held by the practice. Governance arrangements in place ensured that GPs were aware of dates of safeguarding meetings with the local authority, and when any reports on the health and welfare of any safeguarded patients were due for submission. When we reviewed this system we saw that it had worked well in practice. Also, the practice had

offered to host safeguarding meetings to increase the opportunity for GPs to attend these. The practice highlighted records of patients who had previously been subject to a safeguarding plan. If a patient's safeguarding status had changed, for example, to that of a looked after child, this was annotated on records, in a place where the information could be seen by out of hours services. Registers held at the practice were generated from the practice computer system and we saw that governance systems ensured information was updated without delay.

There was a chaperone policy in place at the practice and details of this were available to patients. The chaperone service was highlighted on notice boards and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had received chaperone training. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones. All staff undertaking chaperone duties had been subject to a Disclosure and Barring Service (DBS) check. (DBS 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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely, used in date order and were only accessible to authorised staff. Checks were in place to ensure medicine stocks were rotated and were within their expiry date. There was a cold chain policy in place, which staff could refer to. This gave guidance on safe temperature controlled storage and described the action to take in the event of a failure in continuity of the cold chain. Records showed fridge temperature checks were carried out at least twice daily, which allowed staff to respond quickly to any rise in fridge temperature, beyond the range considered as safe for storage of some medicines.

All prescriptions were reviewed and signed by a GP before being issued to the patients pharmacy of choice or to the patient directly. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance. We saw that access to these was appropriately restricted and batch numbers issued to the practice and then individual clinicians was recorded.

The practice said they had a good working relationship with the local clinical commissioning group (CCG) medicines management team. A partner from the practice had recently attended a training updates course on prescribing and spotting patterns of addictive behaviour in relation to some medicines. Learning from this was shared within the practice and with other practices that were part of the same local federation of practices. We saw records of practice meetings where prescribing protocols were discussed and the actions taken in response to a review of prescribing data.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. For example, the practice used an electronic system which managed patients on Warfarin. This system integrated information into the practice clinical system, recording warfarin levels and offering advice on high and low readings. The system also triggered alerts and messages/ actions where necessary. The practice demonstrated it had a system in place to ensure that completed and signed shared care protocol agreements were in place before commencing the medication regime from the practice.

The practice did not keep a stock of controlled drugs, or take controlled drugs from patients for disposal. Patients were advised to take medicines directly to the pharmacy where controlled processes for their destruction were in place. The practice was supplied with a container for the safe disposal of any out of date medicines, for example, from the emergency medicines bag, by the waste management company contracted to remove clinical waste. We saw that this was stored appropriately and disposal of medicines was done safely.

We saw evidence that nurses had received appropriate training and been assessed as competent to administer medicines referred to either under a Patient Group Directive (PGD) or in accordance with a Patient Specific Direction (PSD) from the prescriber. Patient Group Directives are a legal requirement and allow some nurses who are assessed as competent to do so, to administer certain medications, which are named in each PGD, or PSD.

Good

Are services safe?

Nurses at the practice delivered childhood immunisations and vaccinations to patients of the practice, under PGD's. We saw that these had been recently reviewed and were signed by the lead partner at the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, we saw spillage kits to deal with spillage of bodily fluids were available in all treatment rooms and from behind the reception desk. All staff were trained in the use of these kits and could pinpoint the nearest place to access them from. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

One of the practice nurses was appointed as the lead for infection control. This staff member was responsible for bringing any issues to the attention of the practice manager and for sharing updates on infection control. The practice had been audited on infection control in October 2014 by Cheshire and Wirral Partnership NHS Foundation Trust infection control team, achieving a score of 97.28%. Any areas for improvement had been addressed. For example, toys that were not washable were removed from the waiting area. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out re-audits and had confirmed that any improvements identified for action were completed and staff were aware of any updates to the infection control policy for the practice. Minutes of practice meetings showed that the findings of audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment and consultation rooms.

The practice shared a purpose built facility with another practice and other community health teams. Legionella testing was done for the building on 19 June 2015 and a certificate issued to evidence this.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw all equipment was tested and maintained and equipment maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating when the next testing date was due, which was in 2016. A schedule of testing was in place to ensure no pieces of equipment where overlooked. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and fridge temperature gauges.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence 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.

The practice had arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. This was a requirement of all staff including GPs, who covered each other to avoid the use of locum cover.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager was able to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment and training of staff in relation to health and safety. Identified risks were included on a risk log. Each risk was assessed

and rated and mitigating actions recorded to reduce and manage the risk. The practice shared one example of a time recently when there was a rise in cases of childhood Scarlett Fever. The practice followed protocols in place for dealing with notifiable diseases and liaised with Public Health England throughout this period, on the treatment of patients. Staff were given instructions on the fast tracking through to GPs of any particularly unwell children and where necessary, placed patients in a room away from the main reception area.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. Relevant contact details for staff to refer to were regularly updated. For example, contact details of a heating company to contact if the heating system failed. The plan was reviewed annually and the practice manager confirmed that copies of the plan were held on and off site by key staff members.

The practice had carried out a fire risk assessment which was reviewed annually. This included actions required to maintain fire safety. Records showed that staff where up to date with fire training and that they practised regular fire drills. The last full fire safety inspection at the practice was done by East Cheshire Fire Service in April 2015, which the practice had passed. Further fire safety training updates were delivered for all staff in June 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinicians at the practice were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We reviewed minutes of clinical meetings which showed any updated and new guidance was then discussed by clinicians and implications for the practice's performance and patients were identified and required actions agreed.

The practice delivered health checks for a number of patients groups, for example, patients of working age, older patients, those patients with learning difficulties, those with longer term health conditions and any patients vulnerable to unplanned hospital admission. All clinicians used these health check appointments to review medications, offer opportunistic health screening and healthier lifestyle information on things such as weight management. New patients who registered with the practice completed a comprehensive registration form and were offered a health check. At this point, patients would be added to relevant disease registers if appropriate, to ensure they received the help they need to manage any long term health conditions.

Patients who were at a higher risk of unplanned admission to hospital were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met. When patients were discharged from hospital their care plan was updated with details of any new medications, and reviewed to ensure their needs continued to be met.

Management, monitoring and improving outcomes for people

Information about people's care and treatment outcomes was used by the practice to inform clinicians and improve patients' treatment. The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included a heart failure audit, audit of patients' body mass index that were on the combined oral contraceptive pill (COCP), audit of patients on benzodiazepines, a tonsillitis audit and an audit of all significant events that has occurred with the past twelve months. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the tonsillitis audit showed that GPs had not always adhered to the criteria for prescribing antibiotics. Further investigation showed that in cases were antibiotics had been prescribed, and this was outside of the prescribing protocol the reasoning for prescribing had not always been recorded. Learning from this audit was shared at practice meetings and how linking it to QOF data focussed GPs on prescribing protocol and current best practice.

The practice partners treated every cancer diagnosis as a significant event to see if anything could have been done differently or if there were any common signs that had been missed. The partners were also carrying out an audit on cancer diagnosis, to provide further information on referrals made, the speed of these, and whether diagnosis could have been made sooner.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets and had achieved 97.4% of the QOF points available for the year 2013-14. (Data available to CQC at time of this inspection). The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had systems in place to ensure that all updates in respect of a patients care were shared with out of hours services, McMillan nurses and other care professionals involved in the multi-disciplinary team.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, and that staff training for administrative support staff went beyond what is considered as mandatory. We noted a good skill mix amongst the GPs, who led in their area of special interest, for example in dermatology, mental health, minor surgery or care of the elderly. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). We saw that all nursing staff received on-going professional development and maintained their own training portfolio. Practice nurses and GPs used a recognised management tool kit for appraisals.

All staff undertook annual appraisals that identified learning needs. The practice manager worked with staff to develop their skills and identify training that would benefit them as individuals as well as the practice. All staff we spoke with told us the practice was supportive of any training requests they made.

When we reviewed staff files, we saw that all files were uniform in their content. For example, practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and collecting blood. Those with extended roles for example in managing patients with respiratory illnesses, such as asthma and COPD, were also able to demonstrate that they had appropriate training to fulfil these roles.

Where poor performance had been identified this was referred to the partners and appropriate action had been taken to address this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. All blood test results are reviewed by GPs and any difficult cases are discussed at clinical meetings. Out-of hours reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. We found no backlog of patient discharge summaries or letters waiting to be processed. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications worked well in this respect. The practice undertook a yearly audit of follow-ups to ensure all were appropriate and documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings each month to discuss patients with complex needs. For example, in respect of patients with multiple long term conditions at risk of unplanned hospital admission and for those patients with end of life care needs These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. We saw that were any patient had been discharged from hospital, details of any additional medicines prescribed were discussed. We saw that communication between the practice and other health care professionals was good.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the

Good

Are services effective?

(for example, treatment is effective)

ambulance and out-of-hours services. The practice utilised the Summary Care Record of patients to ensure that all health professionals who needed to, could see key information about patients.

Staff used the electronic patient record consistently, ensuring all information from other health care professionals was uploaded to the patient record. All requests from patients, or from their GPs were recorded on this system giving an auditable and traceable record in respect of each patient. Those patients whose circumstances and needs had to be identifiable quickly, had markers on records that could be seen immediately, for example, in the cases of children subject to a safeguarding plan. All staff were fully trained on the system. The practice manager conducted audits on the quality and consistency of record keeping at the practice, and on the application of read codes. (Read codes are used by staff when summarising and updating patients notes, and are used to help GPs identify patients health conditions quickly). The practice was able to demonstrate that read coding was used uniformly by all staff and that any mistakes could be identified and addressed quickly.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and Gillick competency. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. We saw that younger patients were treated in an age appropriate way and information they were given regarding any treatment was written in plain English. We also reviewed a number of easy read documents, used to provide information to patients with learning difficulties, or for those who found reading difficult. Again, these were easy to follow and gave explanations of treatments in a clear and concise way.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was taken and scanned into the electronic patient record. The same procedure applied for fitting contraceptive implants.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice's performance for the cervical screening programme was in line with the national average. There was a policy of giving telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend and we saw that details of any patients who failed to respond to reminders were referred back to the central health service screening team. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

Childhood immunisation rates where very good, with the practice achievement being above the local and national rates for delivery of childhood immunisations.

The practice had produced a coloured diagrammatical interpretation for the pathway for a repeat prescription, and the pathway for a referral to secondary care. The referral to secondary care covered urgent cancer referrals as well as a referral to a specialist consultant, for example, a dermatologist, which may be non-urgent. This set out what a patient could expect, how quickly they would receive an appointment, and whether they could choose and book the place and date they would be seen. It gave timescales for the referrals, for example, those that would be completed in 24-48 hours and those less urgent referrals that may take up to 10 days. When we asked patients we spoke with in the afternoon about this information, they said they thought it helpful, and identified points at which they should ring the practice, if they had not heard anything. We also noted that the facility for patients to weigh themselves and take their blood pressure was available in the waiting area of reception. This gave each patient more opportunity to monitor aspects of their health and well-being, encouraging patient ownership of health care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, which was published in January 2015, a feedback session from patients through the practice Patient Participation Group (PPG) and a complaints, comments and feedback log. The evidence from all these sources showed patients were satisfied with how they were treated, that GPs took time to listen to patients concerns and that they were treated with compassion and respect.

Patients had submitted 18 CQC comment cards sharing their thoughts about the practice. The majority were positive comments about the service, recording high levels of patient satisfaction. The only slightly negative comment was in relation to the length of time it took patients to get through by phone to the practice at peak times of the day, for example at 8.30am. This was an issue the practice was aware of and were looking at what could be done in the short term to address this problem.

The practice had performed well in the NHS England GP Patient Survey, particularly in relation to questions on topics that patients feel strongly about. For example:

- Of **those patients asked,** 84% said they were able to get an appointment to see or speak to someone the last time they tried. The average local score for this question was **82%, and the average n**ational score was **85%.**
- **Of those patients asked** 88% said the last GP they saw or spoke to was good at giving them enough time. The average score locally for this question was **84%, n**ationally **87%.**

Another area where the practice performed well, which patients say they particularly valued was with regard to GPs listening to their concerns.

- **Of those patients asked** 90% said the last GP they saw or spoke to was good at listening to them. The average score locally for this was **88% and n**ationally **89%.**

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception telephones were located away from the front reception desk. The reception desk was shielded by a perspex partition which also helped keep patient information private.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patients told us they were given sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive in this regard.

Consent forms we reviewed that patients were required to complete were easy to read and written in plain English. Patients also commented that where they were required to make a decision about treatment, they were always allowed to go away and consider their treatment options, before giving any decision.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

We spoke with six patients on the day of our inspection. All told us that staff responded compassionately when they needed help and provided support when required. Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services caring?

The practice had worked on three areas within the practice that they wanted to improve on in 2015. One of these was identifying carers quickly, in order to ensure they were adequately supported and that their own health needs were not neglected. The prompt for this was review of data on carer identification, supplied by the CCG which showed the numbers of carers identified in the practice was considerably lower than national statistics indicated. To do this, the practice reviewed signage and literature available in the reception area to check it was prominently placed. All reception staff and clinicians had carers' business cards to issue to patients, which had phone numbers of key contacts for carers, and an information session was delivered at one of the practice PPG meetings. The practice also had a banner made which was displayed at a flu clinic; this prompted those people attending the flu clinic, to think if they knew of any person that was a carer, and direct them to the practice for more information. As a result, the number of carers identified has increased. In July 2013, the practice had 95 patients highlighted as carers; this had risen to 126 in September 2014, and by the end of January 2015, 148 patients had been identified as carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. We saw an example were the practice focussed on three areas for improvement in responsiveness to patient needs. One of those areas was appointment availability for for working people, particularly those with small children. This was in response to feedback from parents who said that getting an appointment first thing was difficult, especially when trying to ring the practice. In response the practice increased the number of nurse appointments after 5.00pm on a Monday evening, up to 8.00pm, and dedicated slots annotated as being 'after school' so that receptionists kept these free for as long as possible. Also, the number of pre-bookable appointments on-line was also increased. The practice had also considered all patient feedback and the success of this 'appointment formula' when structuring increased access with funds from the Prime Ministers Challenge Fund.

Tackling inequity and promoting equality

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. One of the examples given by the practice was information they were supplied with from the Deafness Support Network Audit. This information identified access issues that deaf patients experienced at their GP practice. The practice reviewed patient records and found 778 patients on their register had a READ code indicating some sort of hearing impairment, which equated to 9% of the practice population. The practice took positive steps in areas they had identified themselves as falling short on. For example, all staff were trained in the hearing loop system; previously only certain staff had been trained in its use. The process for booking an interpreter for patients using British Sign Language is now embedded and staff can refer to a flow chart to do this. All referral letters now advise any health care professional of the patient's status, i.e. whether they are fully or partially deaf and of what support they may need. The information was also shared with the Patient Participation Group (PPG) and members have been asked to encourage any patient who may have hearing difficulties to join the group or to contribute on an ad-hoc basis to ensure the needs of deaf patients are met.

Access to the service

Comprehensive information was available to patients about appointments on the practice website, and in leaflets available in the reception area. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice, with input from one of the GP partners.

Information was available to help patients understand the complaints system. The practice had produced an information leaflet which detailed how patients could make a complaint or raise a concern, and named contacts were given in the leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We reviewed a selection of complaints the practice had received in the past 12 months. We saw that the practice manager recorded all complaints, whether formal or informal. For example, if a patient had complained to reception staff that they had waited for longer than 20 minutes after their appointment time, this was recorded. We saw that all issues raised had been responded to and any formal complaints were dealt with in line with the complaints policy of the practice. All written responses were made within the timescales set out in the policy.

All complaints were logged by the practice, and these were reviewed annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Strong governance processes underpinned all functions within the practice. Leaders recognised how this enabled them to measure performance and to align the growth of the practice to their vision of how health care could be delivered. For example, by providing more integrated care and treatment services, and hosting services for patients that would usually be accessed at the local hospital. All staff we spoke with had a good understanding of the practice vision, and their role in helping the practice achieve this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Staff could access these through the shared drive on the practice computer system. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure in place at the practice, with all five partners having lead roles in specific areas, such as safeguarding and near patient testing (tests carried out within a consultation). There was a lead nurse for infection control and nurses were being developed to take overall control of chronic conditions management. We saw that nurses had good access to GPs for clinical support and guidance and systems in place ensured clinical oversight. Members of staff we spoke with said they felt supported and were clear about their own roles and responsibilities.

The practice manager took an active leadership role in overseeing systems in place at the practice to monitor the quality of the service, were consistently used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice manager had also undertaken a number of audits aimed at consistently improving practice performance. For example, audits of action plans produced to ensure corrective actions had been taken in the time specified. Action plans had been logged and we could see from the log that task completion dates had been added. For example, in relation to ensuring that training for a health care assistant in ear syringing was up to date and complete.

The practice also had an on-going programme of clinical audits which it used to monitor quality, and systems to identify where action should be taken. Audits we reviewed included prescribing audits and audits of patients' body mass index who were treated with the combined oral contraceptive pill. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

Leadership, openness and transparency

The partners in the practice were visible, approachable and took the time to listen to members of staff. All staff were involved in discussions about how the practice operated on a daily basis, and how the practice could be developed in the future. The partners encouraged all members of staff to identify opportunities and contribute to discussions on how to improve services for patients.

We saw from minutes that team meetings were held every week. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Staff said they were confident in raising any concerns and felt supported when doing this. We also noted that team away days were held every 6 months. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), and used this information to target three areas for improvement in each year. This helped give direction for the PPG and worked well. For example one of the three areas highlighted for improvement this year, was the identification of carers. Information available from the local clinical commissioning

Are services well-led?

Good

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

group was that the numbers of carers already identified by the practice were way below those expected for a practice of this size. As a result, information sessions were delivered, and access to information within the surgery was improved. As a result 148 patients, who were also carers, were identified at the practice. As a result, these patients would receive additional health care support, to ensure their own health care needs were not neglected.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Nurses told us the partners were particularly supportive of any learning events and that professional development was encouraged for all.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training, but also placed an emphasis on team building exercises. For example, the practice organised a social event every six months that all staff attended. The event for this summer was an outdoors bush craft exercise, to build team working relationships and help highlight staff strengths and areas for potential development.

The practice partners were considering becoming a training practice. In preparation for this, the partners had qualified as training GPs. Although this would be a considerable commitment the practice partners felt the strength of the practice team would lend itself to this potential future development.