

Rock Healthcare Limited

Quality Report

22 Derby Way,
Bury,
Lancashire
BL9 0NJ
Tel: 0161 447 9820
Website: www.rockhealthcare.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	Outstanding	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Outstanding	
Are services well-led?	Outstanding	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rock Healthcare on 14 May 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be good for providing safe, effective and caring services. We found it to be outstanding for being responsive and well led. It was also outstanding for providing services for all the population groups that we assess.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they usually found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had very good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

The areas where the provider should make improvements are:

Summary of findings

- The practice should introduce a documented “cold chain” policy to ensure the safety of temperature sensitive medication.

We saw several areas of outstanding practice including:

- The practice had increased the flexibility of access to appointments and use of co-located services and could demonstrate the impact of this by reduced use of the out of hours service and very positive patient survey results. The practice provided appointments between 8am and 8pm 365 days a year.
- The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than practice nurses.
- The practice had continually reached out to the local community by approaching local bail hostels and centres for the treatment of addiction and ensured anyone attending the practice would be seen by a clinician even if they were not a registered patient.

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?

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

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked effectively with multidisciplinary teams and other services.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Information to support patients' conditions was produced electronically on an individual basis. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was proactive in initiating and becoming part of local projects to improve outcomes for patients. Patients said they usually found it easy to make an appointment with a GP or nurse and that there was continuity of care, with urgent appointments available the same day. The practice had very good facilities and was well equipped to treat patients and meet their

Outstanding



Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

The practice is rated as outstanding for providing well-led services. The practice had a clear vision with quality and safety and care as its top priorities. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning and initiated new projects to improve patient outcomes. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it was working to re-establish its patient participation group (PPG).

Outstanding



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

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice successfully gained additional finance to undertake multi-agency work to improve the quality of care for older people.

Outstanding



People with long term conditions

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

Outstanding



Families, children and young people

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and at weekends, with a location based midwife service being available. We saw good examples of joint working with health visitors and outreach clinics.

Outstanding



Working age people (including those recently retired and students)

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Outstanding



Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, asylum seekers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

Outstanding



People experiencing poor mental health (including people with dementia)

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and GP demonstrated sound knowledge around patients who lacked capacity to make their own decisions.

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

Outstanding



Summary of findings

What people who use the service say

We received 17 completed CQC patient comment cards and spoke with ten patients at the time of our inspection visit. We spoke with mothers with young children, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

We also looked at the results of the 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. For this practice 439 surveys

were sent out with 105 being returned, giving a response rate of 24%. The survey showed that the practice was higher than average amongst practices in the area and nationally:

97% of respondents found the receptionists at the practice helpful

92% of respondents said the last appointment they got was convenient

94% of respondents said the last GP they saw or spoke to was good at listening to them

99% of respondents described their overall experience of this surgery as good

These percentages placed the practice in the top 2% nationally, in terms of patient satisfaction of those who responded to the survey.

Areas for improvement

Action the service SHOULD take to improve

- The practice should introduce a documented “cold chain” policy to ensure the safety of temperature sensitive medication.

Outstanding practice

- The practice had increased the flexibility of access to appointments and use of co-located services and could demonstrate the impact of this by reduced use of the out of hours service and very positive patient survey results. The practice provided appointments between 8am and 8pm 365 days a year.
- The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than practice nurses.
- The practice had continually reached out to the local community by approaching local bail hostels and centres for the treatment of addiction and ensured anyone attending the practice would be seen by a clinician even if they were not a registered patient.

Rock Healthcare Limited

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Rock Healthcare Limited

Rock Healthcare is situated in Bury town centre and close to the M66 motorway. At the time of this inspection we were informed 3,775 patients were registered with the practice.

The practice consisted of three salaried GPs (one female and two male). The GPs are providing general medical services to registered patients at the practice under an alternative provider medical services (APMS) contract. The practice is a "not for profit" limited company. The GPs are supported in providing clinical services by a practice nurse, a nurse practitioner and two health care support workers (HCSW) all of whom are female. Clinical staff are supported by a director of practice management and their team who are responsible for the general administration, reception and organisation of systems within the practice. The practice provides appointments from 8am to 8pm, 365 days a year.

Out of hours service is provided by Bury and Rochdale doctors on call (BARDOC).

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

Detailed findings

- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14th May 2015. During our visit we spoke with all three GPs, both

nurses, a health care support worker, the Director of practice management and reception staff. We also spoke with a pharmacist from the attached pharmacy and patients who used the service.

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

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. The Director of Practice Management told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at minutes of team meetings and confirmed that significant events and incidents were discussed and appropriately progressed. We noted that clinical and non-clinical staff were able to describe a number of significant events and how they had been investigated.

The practice had a system for dealing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Director of Practice Management and sent to the clinical staff for their information. Other alerts were also received directly to the practice clinical systems and alerts to clinical staff created automatically. We were told that audits of safety alerts were planned for the future to ensure systems were effective.

Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Significant events and changes to practice were discussed with practice staff. Action was taken to reduce the risk of recurrence in the future. The GPs completed evaluations and discussed changes their practice could make to enable better outcomes for their patients, for example providing extended surgery times. The Director of Practice Management told us that regular informal clinical meetings were held and that full staff meetings always took place monthly. We looked at the minutes of these meetings and saw that they were well attended and clearly documented.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required. We saw a number of examples of effective engagement with safeguarding issues and it was clear that the practice took its responsibilities very seriously. We were told that the patient list included a large number of people who lived somewhat chaotic lifestyles, for example people on police bail living in a local hostel, which led to regular safeguarding concerns being raised.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3 for children) safeguarding training for those with key safeguarding roles was provided. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Some staff were less familiar with the procedures around whistle blowing; we were told this area of training would be re-enforced.

Practice nurses, health care support workers (HCSWs) and reception staff were available to chaperone patients who requested this service and information about this service was available in the waiting area and posted on consulting room doors. Staff had been trained in how to chaperone. When we spoke to staff they told us that they were confident in performing a role as a chaperone, and told us that the GPs would always explain in full to the patient what they were doing and why. There was a chaperone policy for staff to refer to.

Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of the practice nurses. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the practice internal systems. Prescription security was effective and GPs did not routinely take prescription pads

Are services safe?

on home visits and would return to the practice to issue any resulting prescriptions. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. An electronic system for repeat prescriptions was available for patients. The practice had a pharmacy located immediately next door, this made it easy for patients to collect their prescriptions and any confusion or questions relating to prescribed medicines could be quickly dealt with. We spoke to the pharmacist who told us they enjoyed an effective working relationship with the practice.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We saw that there were purpose built fridges all kept in locked rooms, equipped with locks and devices for monitoring maximum and minimum temperatures. We saw that systems were in place to check temperatures of the fridges and to effectively manage the stock contained within them.

No cold chain policy was in place at the practice, however staff were clear on the process for dealing with temperature sensitive medicines and the Director of Practice Management told us that a documented policy would be completed as soon as possible.

Cleanliness and infection control

We found the practice to be clean at the time of our inspection and patients we spoke to confirmed that this was always the case. Systems were being developed for managing infection prevention and control. We saw that an audit relating to infection control had been completed by the CCG with good results. One of the nurses had been recently appointed as the lead for infection control and was developing an audit regime to compliment the work completed by the CCG. We spoke to the Director of Practice Management about reviewing and updating the infection control policy, they told us it was currently being done and the lead nurse would attend enhanced infection control training the near future. All clinical staff had already undertaken training in infection control. Much of the responsibility for the cleaning of the practice lay with the building owners with whom the management were in regular contact.

We saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items

were seen to be readily accessible to staff in the relevant consulting/treatment rooms. Spillage kits were available for use by staff who had been trained in their use. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and there was a protocol in place. A receptacle in the waiting area was available for patients to leave any samples that required analysis.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques, some toilets were missing these signs and we were told that this would be addressed.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use; were fixed to walls and were positioned out of the reach of small children. Legionella risk assessments and testing had been completed.

Equipment

There were contracts in place for annual checks of fire extinguishers and calibration of equipment such as fridges and other electrical devices. There was a system in place for the scheduling the testing of portable appliances (PAT) of non-clinical electrical items, for example kettles, printers and computers, we checked a number of these and all had been tested appropriately. Documentation evidenced that other equipment in use was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not. We looked at medical equipment at the practice which was in readiness for use and found that it was all within the manufacturers' recommended use by date.

Staffing and recruitment

The provider recruitment policy was in place and up to date. We looked at staff files and saw all of the employment

Are services safe?

checks that were required to be carried out had been completed. The GPs had regular checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses and receptionists who carried out chaperoning duties also had disclosure and barring service (DBS) checks completed. Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The practice had undertaken a capacity and demand review to check on its ability to manage differing demands; this had resulted in the duty GP rota being developed. Any sickness was closely monitored and return to work interviews were routinely completed. Support was given to staff where possible when they required it with issues related to sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. Staff told us that teamwork was very good at the practice and that this ethos continued throughout the management structure.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually

where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Director of Practice Management if an accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy this and all other practice policies were available to all staff at any time via a shared area on the practice computers. We spoke to the Director of Practice Management who showed us the new computer system for storing policies and guidance. When we asked staff about the new system they were enthusiastic about its ease of use and accessibility.

Arrangements to deal with emergencies and major incidents

Basic life support training was completed annually with all staff and this included using a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and fire alarm tests were completed regularly.

We saw appropriate emergency equipment and emergency drugs were available and staff knew where these could be located. We saw that emergency drugs and equipment were regularly checked by the practice nurses to ensure it was operative and within the manufacturer's recommended usage date.

A documented contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services; this plan was also available using a mobile telephone application. Staff we spoke with were aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and HCSWs. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance.

The practice had a system for reviewing patients with specific conditions. The Director of Practice Management showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included chronic obstructive pulmonary disease (COPD), asthma, diabetes, heart disease, hypertension, rheumatoid arthritis and epilepsy. In addition to the longer 15 minute appointment slots that the practice used, patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. The practice maintained a system where patients were sent recall letters to remind them about reviews; if these were not answered then an electronic note would appear on the patient's notes to alert GPs at their next appointment.

Care plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and heart failure. We reviewed a sample of these care plans and saw they were detailed; patient centred and could be used by other health professionals to make informed decisions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all clinical staff to continually review and discuss new best practice guidelines. The new IQ computer system was seen by the practice as an effective method of making guidance and good practice available to all staff at any time. This system enhanced the learning available from formal training, their e-learning system, practice meetings and ad hoc discussions.

Multi-disciplinary meetings were held regularly to discuss individual patient cases to ensure that all treatment options were considered. The clinicians aimed to follow

best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff meetings and local forums where appropriate.

This practice had achieved consistently high scores for QOF over recent years which demonstrated they provided good effective care to patients. (Total QOF points 97.2% which is 2.2% above the CCG average). The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. QOF information indicated that patients with long term health conditions received care and treatment above the national average including, for example patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had high uptake rates for NHS health checks. Data showed that Rock Healthcare was performing over 35% higher than the next best performing practice in the Bury area.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG audits. One audit we looked at conducted by the practice involved a review of patients at risk of developing diabetes and the lifestyle advice they should receive. Another audit completed by the practice examined heart failure cases and whether appropriate treatment was provided. The practice had identified that a more strategic plan around clinical audits was required as currently they were undertaken on a more ad hoc basis.

Are services effective?

(for example, treatment is effective)

The practice confirmed that peer review of clinical decision making was completed on a regular basis in clinical meetings, during case discussions at palliative care meetings, during reviews of admissions avoidance and by ad hoc discussions.

The GPs, nurses and HCSWs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as end of life care, controlled drugs and safeguarding. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. We received a number of positive testimonials from partner agencies about the excellent working relationships and professionalism of Rock Healthcare.

Effective staffing

All the staff we spoke to at the practice were very complimentary about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice.

Most reception staff were long serving and they knew the regular patients well. There was an induction process for any new staff which covered areas such as the introduction to policies and procedures, confidentiality and health and safety issues.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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 practice and remain on the performers list with NHS England). All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals

from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives. We received very positive testimonials from strategic partners including Bury CCG sector liaison manager and the regional manager of the Priory Highbank centre. We saw that the practice worked collaboratively with Bury Urgent Treatment Centre and other Practices via the Bury Practice Managers Forum, both of which the Director of Practice Management was the chairperson. We noted that the practice had engaged in the "Care about cost" campaign and had limited the number of its patients' attendance at Accident and Emergency (A&E) to 0.4% rise over the past five years. Other A&E's in the area were averaging an 8.7% rise over the same period. We were told that this had been achieved by a stringent regime of patient information and encouraging the use of the facilities available within the Bury Urgent Care Centre, which was co-located with the practice. Effective triaging of patients and their presenting conditions meant that the practice was able to signpost patients to the best longer term service or clinician and this helped reduce the need for attendance at A and E.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients. The practice had dedicated members of staff for updating information on systems and electronically capturing associated documents.

Information sharing

GPs met regularly with the practice nurses and the Director of Practice Management. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Director of Practice Management attended CCG meetings and disseminated what they had learned in practice meetings. Regular meetings involving all team members kept staff up to date with current information around enhanced services, requirements in the community and local families or children at risk.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings.

Are services effective?

(for example, treatment is effective)

The GPs and the Director of Practice Management attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Director of Practice Management regularly organised and chaired area practice managers meetings to share information about their role discuss best practice and maintain their professional knowledge. There was an informative practice website with information for patients including signposting, what clinics were available and prescription information. There had been a patient participation group (PPG) established at the practice. The Director of Practice Management told us it was a priority to re-establish this group as they saw it as an important method of maximising communication with the patient group.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers so that clinicians were aware that consent to treatment may be an issue for consideration. A consent policy was in place at the practice and staff were able to access this via a shared area on the practice computer systems and via the new IQ system.

GPs and clinicians had received training in the Mental Capacity Act and we saw evidence from GPs that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. We looked documented examples of where one of the GPs had been involved in making a best interest decision for a patient, we saw appropriate people had been consulted and an auditable document trail had been completed.

The 2015 national GP patient survey indicated 95% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 82% said the last GP they saw or spoke to was good at involving them in decision making and 98% had confidence and trust in the last GP they saw or spoke to. These percentages were above the average for the area.

Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse or the HCSW. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. Where there were issues identified that required more detailed consultation, then patients were referred to one of the GPs. The practice provided a weekly weight management clinic for patients needing assistance in this area of their lives.

The practice provided a self-funded nutritionist to assist patients with weight management; we saw specific examples of how this had been effective in reducing patient's body mass index (BMI).

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. Clinical staff at the practice were able to produce individualised printed healthcare advice for patients via practice computer systems.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to 10 patients in person and received feedback from 17 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the nurses, the reception staff and the GPs. We noted that clinical staff always met their patients in the reception area in person, before the appointment and consultation took place.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use in rooms during physical and intimate examinations and a chaperone service was offered. Staff had received training on how to be an effective chaperone. When we spoke to staff about carrying out their chaperoning, they were confident about how to best perform the role.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in information security, equality and diversity, safeguarding children and adults and information governance. We also noted that there were practice policies to cover all these areas which staff could access via a shared area on the practice computers and via the IQ portal.

We looked at the results of the 2015 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 87% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern (National average 85%). 97% of respondents said the last nurse they saw or spoke to was good at listening to them (National average 91%). These percentages were higher than those for most other practices in the area.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them

in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians, the practice website and prominently displayed in the waiting areas. The practice was able to produce bespoke printed health information for each individual patient based on their individual information. 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 patients this service was available.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2015 GP patient survey reported that 82% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care (CCG average 81%). 97% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments (CCG average 91%). These percentages were higher than most other practices in the area.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or a vulnerable. We saw there was written information available for carers to ensure they understood the various avenues of support available to them.

One of the GPs took the lead for palliative care. The practice maintained a palliative care register and held

Are services caring?

regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We looked at minutes of these meetings and saw that they were well written and comprehensive. Patient care plans and supporting

information informed out of hours services of any particular needs of patients who were coming towards the end of their lives. The practice maintained a register of carers and ensured they were offered regular health checks and received information relating to support available.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, practice management meetings, local area team meetings and meetings with Macmillan and district nurses. The practice was effective in assessing and providing medical services to vulnerable people, we saw examples of how the practice had worked closely with the probation service and the local bail hostel to ensure patients who could present danger to others were still afforded appropriate medical treatment. We saw a testimonial from a probation service manager praising the practice staff on their effectiveness in providing service to patients who found themselves in difficult circumstances.

The practice made use of a kiosk in the waiting area so that patients were able to express their views in various formats. This kiosk was shared with other services located in the same building and sharing the same waiting area. The Director of Practice Management had plans to use a tablet device so that patients could more easily record their views.

Patients were able to access appointments with a named doctor and all patients over 75 had a named GP. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP, many preferred to wait for a later appointment in order to see that GP. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Although routine appointments were already five minutes longer than most practices, longer appointments could be made for patients such as those with long term conditions or with more than one condition they wished to discuss. Clinical staff regularly conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. The practice worked collaboratively with partners such as Bury Urgent Care Treatment Centre to provide services for vulnerable groups such as asylum seekers, those with alcohol and drug dependencies and homeless people. Regular meetings involving services who provided support for these groups ensured that the practice maintained a clear picture of their needs.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews. A documented system was in place to ensure that people who required regular reviews were contacted and a suitably long appointment was scheduled in order to meet their individual needs.

Rock Healthcare had a reception area (shared with other services) and sufficient consultation and treatment rooms. The building was easily accessible to patients including those with a disability. We noted there was a hearing induction loop available for patients who may require one.

Tackling inequity and promoting equality

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

The practice provided information for people whose first language was not English as well as interpreter services. There were good communication links with the local homeless, those living in bail hostels and vulnerable people services, which were able to provide information on



Are services responsive to people's needs?

(for example, to feedback?)

the medical requirements of this group of people. Asylum seekers were able to register at the practice and receive the same levels of care as any other patient on production of appropriate documentation.

Access to the service

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information pack given to all new patients. The practice was open every day 8.00am to 8.00pm and 365 days a year. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

There were some negative comments made by patients we spoke to about being able to access appointments at the practice; the Director of Practice Management told us they were continually reviewing this area. The practice had introduced a telephone triage appointment system that was facilitated by the GPs; this was proving effective in ensuring that patients received an appropriate response to their requests.

We looked the results of the 2015 GP survey 97% of respondents found the receptionists at the practice helpful (National average 87%), 92% of respondents said the last appointment they got was convenient (National average 92%) and 91% of respondents described their experience of making an appointment as good (National average 74%). These percentages were higher than most other practices in the area and nationally.

GP appointments were provided in fifteen minute time slots and were pre bookable; longer appointments were available for patients with more than one issue for discussion. Appointments could be accessed by telephone, in person or on line. Urgent appointment slots were kept available throughout the day with one of the GPs always 'on call' during surgery hours. Telephone consultations were used when appropriate. One female and two male GPs were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The Director of Practice

Management told us that they were constantly reviewing patient demand and appointment availability, responding to it by altering the patients booking system to ensure it was always effective.

The practice used an electronic messaging system to aid communication between administration staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service. The practice operated an effective referral system to secondary care (hospitals), using a "choose and book" method, where the patient could choose a suitable appointment based on advice provided by the clinician.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Practice Administrator was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system both within a practice complaints and comments leaflet as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint and felt confident in doing so should the need arise.

In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints. We saw that complaints had been reviewed so that any learning and potential improvements could be identified. One example we saw related to a patient complaint regarding a failure to refer in a speedy manner, once investigated it was clear that there had been a breakdown in communication and new systems were put in place to prevent a re-occurrence. We noted that due to a complaint regarding the manner of one member of staff, the practice had arranged for all public facing staff to undertake a customer service training course. There had been no further complaints of a similar nature.

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

There was a clear leadership structure at the practice and staff were aware of how the management structure operated and their responsibilities. Each of the GPs had specialist skills or areas of interest which were known to staff and shown on the practice website. GPs were able to share their knowledge with the rest of team and this had proved effective in helping staff professionally develop. Nursing staff with whom we spoke told us how there was excellent team work and how GPs were always ready to provide advice and guidance on clinical matters and how the practice management team were provided high levels of support in non-clinical matters.

We saw that the practice had a mission statement to its patients. We asked staff about the statement and they were clear on what they were trying to achieve as a practice and how each of them contributed to the overall aim.

We spoke to the Director of Practice Management and the GPs about the vision and values of the practice; they told us that they had become part of the ethos of providing the highest standards of care possible. We asked them about how the practice mission statement was formalised with staff so that they became part of their overall personal objectives. We were told that whilst not formally documented, they already formed part of team goal of continuous improvement. Staff we spoke to confirmed that this was the case and that they were clear on trying to achieve excellence.

Governance arrangements

The practice held regular documented meetings for clinicians and management. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were

produced to maintain or improve outcomes. We saw evidence that showed the GP and Director of Practice Management met with the CCG on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. The practice had taken part in a number of CCG led initiative to improve services, for example avoiding unplanned admissions (to hospital).

The practice had a system in place for clinical audit cycles; we saw several examples of these having taken place. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. Any learning about audits and other clinical issues were shared with other partner teams such as the Bury Urgent Treatment Centre colleagues, CCG Sector meetings, local practices and the practice managers forum.

Leadership, openness and transparency

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

We saw staff undertook annual appraisals and these were completed in a timely manner. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. We noted that clinical staff had annual appraisals whereas non clinical staff had structured one to ones with their line manager. The practice had plans in place to introduce 360 degree feedback as part of their improvements to the way appraisals were conducted. The practice had a clear and effective business plan which was aimed at improving services for its patients.

The Director of Practice Management was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and health

Are services well-led?

Outstanding



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

and safety, which were in place to support staff. Staff we spoke with knew where to find these policies if they required them for review. The recently introduced IQ system for information and guidance had proved very popular and effective. Staff were quickly able to find information on the system when we asked them.

We were told that support for learning, development was very good. Documented peer reviews of clinical decision making were evident. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the Director of Practice Management. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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

The practice had gathered feedback from patients through patient satisfaction surveys, comment cards and complaints received. We looked at the results of the 2015 GP patient survey it reflected high levels of satisfaction with the care, treatment and services provided at Rock Healthcare resulting in it achieving a top 2% position in satisfaction nationally. The practice conducted regular patient surveys to help them gauge feeling and needs of their patient group. A PPG had formerly been established, but this had failed to continue, the practice saw the re-establishment of a PPG as priority so it could maximise the methods of communicating with its patient group

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with clinical staff during meetings to ensure outcomes for patients improved. We noted that the practice was very open and transparent in sharing any errors and issues of concern.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. All clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.

The practice had utilised innovative methods of identifying ways to improve, they had documented these, discussed them at practice meetings and identified methods and timescales for improvement. One example was use of a "smart sheet" to utilise the Health and Social Care Regulations to benchmark the practice performance in achieving compliance with the regulations. All staff at the practice were encouraged to add data to the sheet to identify potential improvements which could be discussed and progressed.