The Lakes Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected The Lakes Medical Centre on the 8th October 2014 as part of our new comprehensive inspection programme.

Our inspection team was led by a CQC Inspector and a GP. The team included a practice manager and an expert by experience. We reviewed information provided to use leading up to the inspection and spent seven hours on-site speaking to 13 members of staff, nine patients and reviewed 36 CQC comment cards which patients had completed leading up to the inspection. From all the evidence gathered during the inspection process we have rated the practice as good.

During our inspection the majority of comments from patients were positive about the care and treatment people received. Patients told us they are treated with dignity and respect and involved in making decisions about their treatment options.

A small number of patients reported difficulty in making timely routine appointments with a GP, however they reported where emergency appointments were required these were accommodated on the same day.

Feedback included individual praise of staff for their care and kindness and going the extra mile.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.
- Staff understand their responsibilities to raise concerns, and report incidents.
- The practice is clean and well maintained.
- There are a range of qualified staff to meet patients' needs and keep them safe.
- Data showed us patient outcomes were at or above average for the locality. People's needs are assessed and care is planned and delivered in line with current legislation.
- The practice works with other health and social care providers to achieve the best outcomes for patients.

Summary of findings

- Majority of patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day.

We saw several areas of outstanding practice including:

- The care for patients at the end of life was outstanding. The practice had a lead GP for end of life care within the practice, and a GP who took a lead within the CCG for developing end of life care within Salford. The practice had carried out an end of life care audit, which showed that 100% of patients in the latter stages of life had a statement of intent in place. A statement of intent is where all palliative care patients expected to be on their last days, should with consent have information shared with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.
- The practice provided an enhanced service for refugees. The purpose of this enhanced service was to deliver primary medical care to refugees placed within Salford by providing patient centred, systematic and on going support during the 12 months following arrival and beyond. The practice provided refugee patients with access to all services.

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

Importantly the provider should:

- Devise a policy and procedures for staff to ensure guidance and continuity in relation to consent, or guidance for staff on how to take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Majority of patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver this. Staff were clear about the aims and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients and two members of the patient participation group. We reviewed 36 CQC comment cards which patients had completed leading up to the inspection.

The majority of comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

A small number of patients reported difficulty in making timely routine appointments with a GP, however they reported where emergency appointments were required these were accommodated on the same day.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 91% of respondents would recommend this surgery to someone new to the area and 88% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. Results also showed 87% were able to get an appointment to see or speak to someone the last time they tried and 95% say the last appointment they got was convenient.

We saw the patient participation group conducted a survey in March 2014 with 126 patients (1.5% of the Practice population) in which they found:

- Reception- a total of 80 % of respondents rated this as excellent, very good or good. 11 % rated reception as satisfactory. 8 % rated reception as poor or very poor.
- Opening times - a significant majority (90%) of the patients surveyed found the current opening times of the practice convenient.

Areas for improvement

Action the service SHOULD take to improve

There was no policy and procedures in place for staff to ensure guidance and continuity in relation to consent, or guidance for staff on how to take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005.

Outstanding practice

The care for patients at the end of life was outstanding. The practice had a lead GP for end of life care within the practice, and a GP who took a lead within the CCG for developing end of life care within Salford. The practice worked within the Gold Standard framework, working as part of multi-disciplinary team and out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes. The practice had carried out an end of life care audit, which showed that 100% of patients in the latter stages of life had a statement of intent in place. A statement of intent is where all palliative care patients expected to be on their last days, should with consent have information shared with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes. The audit and findings were presented to a national audience at the Royal College of General Practitioner Conference in September 2014 as an example of good practice.

The practice provided a gateway protection for refugees as part of an enhanced service. The purpose of this enhanced service was to deliver primary medical care to gateway protection refugees placed within Salford by providing patient centred, systematic and on going support during the 12 months following arrival and beyond. The practice provided refugee patients with access to all services. The patients were registered on arrival and seen as and when required. The practice

Summary of findings

provided support to the patients and their dependants to understand how to use the NHS and signpost them to other appropriate healthcare resources when needed. For patients where English was their second language, a face to face interpreter could be arranged within 24hours, or immediately over the phone, this is in line with good practice to ensure people were able to understand treatment options available.

The Lakes Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team included a practice manager and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to The Lakes Medical Centre

The Lakes Medical Centre provides primary medical services in Swinton, a district of Salford from Monday to Friday. The practice is open between 08:00 and 19:30, with the exception of Fridays when the practice closes at 18:30. The practice provides home visits for people who were not well enough to attend the centre.

The practice has seven GP partners, five male and two female, supported by two full time nurses and a full time health care assistant. The Lakes Medical Centre is a teaching practice and has one Foundation Doctor year 2 (FY2: Foundation Doctor is compulsory for all newly qualified medical practitioners) and one GP registrar. The practice is supported by a practice manager, receptionists and a secretary.

The Lakes Medical Centre is an accredited GP Training Practice by the North Western Deanery of Postgraduate Medical Education.

The Lakes Medical Centre is situated within the geographical area of NHS Salford Clinical Commissioning Group (CCG). The CCG is comprised of 50 GP practices serving a population of approximately 250,000 people across the eight neighbourhoods of Irlam, Swinton, Broughton, Eccles, Ordsall, Claremont, Little Hulton and Walkden.

The Lakes Medical Centre is responsible for providing care to 8506 patients,

When the practice is closed patients were directed to 111 for out of hours service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 8th October 2014. The inspection team spent seven hours at the Practice. We reviewed information provided on the day by the practice, observed how patients were being cared for and reviewed a sample of anonymised patient records

We spoke with nine patients, 13 members of staff and two members of the patient participation group. We spoke with a range of staff, including receptionists, the office manager, the practice manager, five GPs, two practice nurses, health care assistant, Foundation Doctor and a GP registrar.

Detailed findings

We reviewed 36 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place to monitor patient safety. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an achieving practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk and near misses. All staff we spoke with were aware of the procedure for reporting concerns and incidents. We reviewed significant event reports and saw that appropriate action had been taken and where changes to practice were required this had been cascaded to staff.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice. We noted in all the consulting room guidance displayed from the National resuscitation council to guide staff should a patient require emergency care.

The practice had systems in place to respond to safety alerts.

The practice investigated complaints, carried out audits and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, through monthly multi-disciplinary meetings with other health and social care professionals.

We saw patients who required annual reviews as part of their care, a system was in place to ensure reviews took place in a timely manner. We heard from these patients that staff invited them for routine checks and to remind them of appointments at the clinics.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. The practice had in place arrangements for reporting significant incidents that occurred at the practice. We saw from the practice significant events log and speaking with staff, they had carried out detailed investigations and

provided detailed records of outcomes and actions taken in light of the significant events. Monthly meetings had been introduced in September 2014 for relevant staff to discuss findings and plan action to be taken in light of significant events. All staff told us the practice was open and willing to learn when things go wrong, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Staff told us learning from incidents was shared via team meetings and email.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible. We saw all staff had completed safeguarding training and had received annual updates.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. We saw procedures and flow charts were in place for staff to follow should they have concerns about a patient. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who had responsibility for safeguarding; they had completed training to level three and were knowledgeable about the contribution the practice could make to safeguarding patients. The practice was proactive in contributing to multi-disciplinary child protection meetings and serious case reviews. The safeguarding lead attended local safeguarding lead meetings and completed reports when necessary for child and adult protection case conferences, attending where possible.

Good

Are services safe?

A chaperone policy was in place and we saw several notices alerting patients to the availability of a chaperone. Speaking with staff who acted as chaperones, they were clear of the role and responsibility and had received training.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such

as administration of vaccinations. The practice had in place Standard Operating Procedures for controlled drugs in line with good practice issues by the National Prescribing Centre.

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

GPs reviewed their prescribing practices as and when medication alerts were received. Staff told us information and changes to prescribing were communicated during meetings, or via email alerts. Staff told us they regularly discussed and shared latest guidance on changes to medication and prescribing practice. A member of staff from the CCG visited the practice on a weekly basis to support the practice with medicines management, working alongside the lead GP for medicines.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines including those used by the GP for home visits and found these were in date, stored safely and where required, were refrigerated. Clear records were kept whenever any medicines were used. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. We saw within the four patient records we reviewed, medicine reviews had taken place where required and all the patients we spoke with told us they had, had their medicine reviewed.

We were shown the safety checks carried out in relation to prescriptions being issued. The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by a GP were locked away in a secure drawer. A nominated member of staff was responsible for prescription ordering, management handling and recording date of receipt, serial numbers and date issued for use internally. We saw prescriptions for collection were stored behind reception desk, out of reach of a patient. At the end of the day we were told these are locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them.

Some patients we spoke with raised concerns about the electronic prescribing service, in which the prescriptions were not always available at the pharmacy of choice. The practice were aware of this issue and were working with the providers of the computer system and pharmacists to resolve the problems and continued to monitor the situation.

Cleanliness & Infection Control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed.

We saw up to date policies and procedures were in place, the policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

We saw staff had received infection control training; all staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities. We saw a clinical equipment cleaning checklist was displayed in each room.

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

A cleaning schedule was in place which gave detailed guidance to the contracted cleaning staff of the weekly tasks and a rota for additional deep cleaning. A risk assessment was in place for the cleaning of the practice and an annual audit was carried out.

Good

Are services safe?

We noted a colour coding scheme in place was in line with good practice guidelines to ensure cleaning materials and equipment were not used across all areas. This was to prevent the spread of infection.

The practice carried out an annual infection control audit; we saw the outcomes of the last audit in January 2014, in which they scored 95% compliance. Areas of improvement had been identified and actioned.

We looked in four consulting, rooms all the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains in each room had been cleaned, with labels detailing the next scheduled date for cleaning. The curtains were routinely cleaned on a six monthly basis, or as and when required.

The cleaning company carried out monthly Legionella testing, recording this and raising any concerns with the practice manager.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with Manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment, this included the defibrillator and oxygen.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic button for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date We looked at the recruitment and personnel records for four staff. We saw recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that disclosure and barring checks (DBS) had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff. For all other staff, the practice manager planned to risk assess the roles and responsibilities of the administration and reception staff to see if DBS checks were required.

Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs, nurses had been allocated lead roles to make sure best practice guidance was followed in connection with infection control, safeguarding and training. Speaking with GPs and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Appropriate action was taken to respond to and minimise risks associated with patient care and premises. We saw evidence that all clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaplaxyic shock.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. Each GP had a copy of the plan, and a neighbouring practice had been identified as back up should it be required.

We saw fire safety checks were carried out and full fire drills were scheduled every six months. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR).

Good

Are services safe?

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff completed assessments of patients' needs and these were reviewed when appropriate, we saw within the four patient records reviewed by our GP, in which they saw comprehensive assessments had taken place, test had been requested and referrals made within time frames recommended by the National Institute for Health and Care Excellence (NICE)

Speaking with the practice nurses they explained to us how they reviewed patients with chronic diseases such as Asthma on an annual basis, and were able to make direct referrals to specialist services where required. We saw from The national Quality Outcome Framework (QOF) patients with diabetes had received appropriate tests and treatment and those patients with atrial fibrillation currently treated with anti-coagulation drug therapy or an antiplatelet therapy.

We saw the practice maintained a register of patients with learning disability to help ensure they received the required health checks. We noted all patients' with learning disabilities had access to annual reviews using the nationally recognised Cardiff Health Check Template, recognised by the Royal College of General Practitioners (RCGP) and The Royal College of Nursing (RCN).

The Nurses also carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF provided evidence the practice were responding to the needs of people with poor mental health by ensuring, for example women with schizophrenia, bipolar affective disorder and other psychoses, had had a cervical screening test in the preceding 5 years.

We saw from QOF 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw information available to staff, minutes of meetings and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and nursing staff told us they received regular updates as part of their ongoing training.

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment. Ensuring where necessary young people were able to give informed consent without parents' consent if they are under 16 years of age.

Staff were able to describe how they assessed patients capacity to consent in line with the Mental Capacity Act 2005, speaking with the nurses they told us of situations where they had referred concerns about a patients capacity to the GP safeguarding lead, suggesting a best interest meeting be held, a best interest meeting is a meeting often involving relatives to decide on the best possible care and treatment options for a patient where they do not have the ability to make their own decisions. Speaking with one GP they told us, where concerns were identified about a patients capacity, a referral would be made to the community psychiatry team. We noted some staff had received training in relation to mental capacity, the two GPs responsible for delivering training and support to the GP registrars at the practice were accredited for providing MCA training. Were told additional training had been arranged by Salford CCG, which GP's would be attending to continue to ensure the Mental Capacity Act was implemented effectively across the practice.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers. Individual cases were discussed on a day to day basis to ensure patients and relatives needs were reviewed on a regular basis to meet patients physical and emotional needs.

One GP took a lead for End of Life care across Salford Clinical Commissioning Group. They told us statement of intent documents had been developed, and this was presented at the Royal College of General Practitioner Conference in September 2014 as an example of good practice.

A statement of intent is where all palliative care patients expected to be on their last days, should, with consent have information shared with out of hours providers to ensure consistence of care and a shared understanding of the patient's wishes.

We were told for patients where English was their second language, or for patients who required a sign language

Good

Are services effective?

(for example, treatment is effective)

interpreter, a face to face interpreter could be arranged within 24hours, or immediately over the phone, this is in line with good practice to ensure people are able to understand treatment options available. The practice had access to a full range of language interpreters, this was important as the practice provided support to asylum seekers and refugees.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition. A range of patient information was available for staff to give out to patients which helped them understand conditions and treatments. The health care assistant told us they had access to a full range of patient information at hand via the computer system which they could print out for patients to take away.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

Speaking with GPs and practice manager they told us of the benefit of newly introduced monthly meetings to share knowledge and discuss patient care, and the value of daily informal discussion with colleagues at the end of morning surgery.

The practice used the information they collected for the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2012-2013 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisation were being taken up by parents. NHS England figures showed in 2013 96.7% children under 12 months old had been vaccinated compared to a national average of 95.5% For children at five years of age data showed 97% of children had received their vaccinations, higher than the national average of 96%

Information from the QOF 2012-2013 indicated the practice had maintained this high level of achievement with 94.5% of outcomes achieved, only one point below the CCG average.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing 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. A good skill mix was noted amongst the GPs, nurses and health care assistant, and patients had an option of seeing male or female GPs. We noted majority the GPs had additional qualifications in specialist areas such as dermatology and family planning. We saw two GPs also worked within a local Hospice.

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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice.

New staff including a Foundation Doctor and a GP registrar participated in an induction programme. We saw an induction checklist was in place to ensure all areas were covered. Speaking with one new member of staff and the GP registrars, they were very complimentary of the induction process and felt welcomed and supported into the practice.

The practice had a system for supervision and appraisal in place for all staff. We saw appraisals were up to date and the staff we spoke with confirmed appraisals had taken place. Foundation Doctor and a GP registrar had weekly tutorials with the GP training lead.

Good

Are services effective?

(for example, treatment is effective)

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw staff had access to training as part of their professional development with nurses attending training in which updates on key issues was provided. One receptionist told us they had had the opportunity to complete a five day course on the role of a receptionist, which they found beneficial to their role.

Working with colleagues and other services

We found the GPs, nurses at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. GPs and nurses attended monthly a multi-disciplinary team meeting to ensure information was shared effectively.

For patients who were homeless, they were referred to a specialist GP service locally. The practice had links with the alcohol and drug services which they could refer patients. For patients wanting access to talking therapies a counselling service was provided on-site and referrals could be made to the specialist mental health team or the Child and Adolescent Mental Health Service (CAMHS). The practice nurses told us they worked alongside the diabetic nurse, who supported patients who were insulin dependent in the community. Health trainers visited the practice on a weekly basis to engage patients and provide healthy lifestyle advice and guidance.

The practice raised concerns about the links they had with health visitors and the withdrawal of the Midwifery service on-site and the impact this may have on patient care and joint working. They had expressed their concerns with local commissioners and the CCG. Concerns were also raised with us about the withdrawal of the podiatry service, despite the practice responding to the removal of this service by training nurses. They remained concerned about the impact on patient care, and again they had raised their concerns with commissions and the CCG.

Information Sharing

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers. We saw from the results of a clinical audit 100% of patients in their last days had with consent their end of life care plan shared with out of hours providers to ensure continuity of care and patient's wishes were considered.

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Shared care protocols were in place for specific medication. Medicines initiated in hospital or by a specialist for example and prescribed for potentially serious conditions or at the end of life. A shared care protocol enables a patient to return home and allows the prescribing of specialist medication to be transferred to the GP from the hospital or specialist.

Consent to care and treatment

There was no policy and procedures in place for staff to ensure guidance and continuity in relation to consent, or guidance for staff on how to take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005. However all staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff told us where they had concerns about a patient's capacity; they would refer patients to the GP.

GPs were able to outline a mental capacity assessment they would use to support them in making assessments of a patient's capacity and outlined the need to keep clear records where decisions were made in the best interest of patients who did not have capacity to make decisions. Where concerns were raised about a patient's capacity, a referral would be made to the mental health team. This

Good

Are services effective?

(for example, treatment is effective)

showed us that staff were following the principles of the Mental Capacity Act and making detailed records of decisions to ensure patients or relatives were involved in the decision making process.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allow professionals to demonstrate they have checked the persons understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. We were told this would be recorded within the patient's record.

We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes, this included vaccinations.

For patients where English was their second language, or for patients who required a sign language interpreter, a face to face interpreter could be arranged within 24hours, or immediately over the phone, this is in line with good practice to ensure people are able to understand treatment option available and give voluntary and informed consent. One receptionist told us of a patient who required a sign language interpreter and although they had access to a relative who could sign, they always ensured an independent interpreter to maintain the patients confidentiality.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details on the practice website or by asking at reception. New patients were provided with an appointment with a member of the nursing team for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion. A health trainer from the Local Authority visited the practice once a week to help improve patients well-being by encouraging and supporting healthy lifestyle choices, patients could be referred to a health trainer for additional support.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patient's annual reviews and health checks.

The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. Patients who wanted support to stop smoking could be referred to an in-house smoking cessation service.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough) Primary. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with nine patients and reviewed 36 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared.

We saw all phone calls from and to patients were carried out in a private office behind reception and not at reception; we were told this helped to maintain patient confidentiality.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms at the side of reception. We also noted a sign at reception asking patients to stand back to allow other patients confidentiality at reception. However we noted from the National GP Patient Survey, only 67% were satisfied with the level of privacy when speaking to receptionists at the surgery. We discussed this with the practice manager who told us they would improve the notices in reception, informing patients they could request to speak in private.

Majority of the patients we spoke with were complimentary about the reception staff and this was also reflected in the National GP Patient Survey where 87% said the receptionists at this practice were helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

We found all rooms were lockable and an electronic system was in place to show when rooms were occupied. All consulting rooms had dignity screens in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

Majority of the patients told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP but they had to wait for appointments.

Patients we spoke with told us the GP and nurses were patient, listened and took time to explain their condition and treatment options. This was reflective of the results from the National GP Patient Survey in which 88% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care.

We saw from The Quality and Outcomes framework QOF data for 2012/13, 98.8% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. This exceeded the national average of 87.4%.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. However there was no policy and procedures in place for staff to ensure guidance for staff on how to take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005.

Staff told us relatives, carers or an advocate were involved helping patients who required support with making decisions. We saw staff had access to pictures to help involve patients with learning disabilities to be involved in understanding and making decisions about their care and treatment. Where required independent translators were available either by phone or face to face for patients where English was their second language. We observed reception staff supporting a new patient at reception to arrange a translator.

We noted where required patients were provided with extended appointments up to 45minutes for reviews with patients with learning disabilities to ensure they had the time to help patients be involved in decisions.

Good

Are services caring?

We found that clinical staff understood how to make 'best interest' decisions for people who lacked capacity and sought approval for treatments such as vaccinations from children's legal guardian. One GP we spoke with described occasions where they have been involved in assessing patient's capacity and best interests, ensuring that where they did have capacity for all or some decisions this was respected.

In reception we saw a notice board specifically for carers, where there was notices to guide patients to support and advice. We also noted other local support services were promoted in the reception areas including a forum for parents of disabled children.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the National GP survey 93% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team. One GP told us they provided families with a direct contact number should they require support. We saw the practice were proactive in providing bereavement support as part of follow up consultations and were looking to develop a template to ensure bereavement was an integral element of follow up with relatives. The practice had an on-site counselling service for patients, and we were told the practice worked closely with the Hospice Chaplin who was able to provide spiritual support to patients and relatives.

The counselling service was available to all patients and promoted within reception.

The Quality and Outcomes framework QOF data for 2012/13 showed for the practice, in those patients with a new diagnosis of depression, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care. The data also showed that 86% of patients with physical and/or mental health conditions notes contain an offer of support and treatment within the preceding 15 months.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice provided a gateway protection for refugees. The purpose of this enhanced service was to deliver primary medical care to gateway protection refugees placed within Salford by providing patient centred, systematic and on going support during the 12 months following arrival and beyond. The practice provided refugee patients with access to all services. The patients were registered on arrival and seen as and when required. The practice provided support to the patients and their dependants to understand how to use the NHS and signpost them to other appropriate healthcare resources when needed.

The practice were proactive in working with patients and families, in a joined up way with other providers in providing palliative care and ensuring patients wishes were recorded and shared with consent with out of hours providers at the end of life.

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The practice were proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments. Home visits were not only provided by GPs but the nurses and health care assistant also provided home visits.

We saw where patients required referrals to another service these took place in a timely manner. This included referrals to in-house counselling and smoking cessation services and externally to drug and alcohol services. For patients who disclosed they were homeless they would be referred to a specific GP service for homeless people.

A repeat prescription service was available to patients, via the website, a box at reception or requesting repeat prescription with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties, however we noted from patient feedback, concerns with the electronic repeat prescription service. The practice were aware of the issues and working with the pharmacy and IT provider to resolve the issues.

The practice had a Patient Participation Group (PPG) with 27 members, who met on a monthly basis, speaking with two members of the PPG they expressed how open and responsive the practice were to feedback and suggestions. We saw from the action plan following a patient survey carried out by the PPG in March 2014 the practice were exploring ways to improve patient experience.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice had recognised different patients' needs when planning services with GPs taking special interests, with one GP chairing the Swinton Neighbourhood Group, this is a group of other GP practices, Local Authority and health and social care providers to look at how the needs of the local community can be best met.

The practice was on one level with access for people with disabilities, or pushchairs and specific parking spaces for patients with a disability. The practice had a hearing loop in place for patients with hearing impairments, and provided sign language interpreters where required. A disabled toilet was available as were baby changing facilities.

The practice ensured that for patients where English was their second language they had easy access to an interpretation service. The practice had in place information in different languages, accessed via the website. These interpretation services ensured patients were able to make informed decisions about care and treatment.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided extended appointments where necessary and appointments were available from 8:00am until 7:30pm to allow people to make appointments out of normal working hours.

We saw from minutes of the PPG discussions were taking place to look at how the PPG could be more reflective of the patient population, this included ways of engaging young people and ethnic minority patients, with suggestion of using social media and targeting recruitment.

Access to the service

The practice had proactively reviewed the appointment booking system, in light of feedback from patients and the PPG, we saw within the action plan following the survey carried out by the PPG and subsequent minutes of PPG meeting the appointment system was routinely discussed exploring ways to make improvements. This included adding more appointments available to be booked online.

Patients were able to make appointments up to eight weeks in advance by telephone or online via the practice website. For same day or emergency appointment patients were required to phone the practice at 8am to get an appointment. This was an area of concern for some patients who told us they struggled to get through on the phone, and by the time they did get through all the appointments had gone. This was reflected in the national GP patient survey with only 71% of respondents saying they found it easy to get through to this surgery by phone, below the average for other practices in the area. However 87% of respondents said they were able to get an appointment to see or speak to someone the last time they tried and 95% say the last appointment they got was convenient.

Not all patients expressed concerns over the appointment system and told us of positive experiences. They told us they were accommodated with appointments within a couple of days, or seen straight away for emergencies. Some patients told us they were called by the practice if a cancellation was made, and offered appointments. We were told by reception staff any children or vulnerable patients would get a same day appointment.

Home visits were available for patients each day by telephoning the practice before 12pm.

Patients were clearly guided to out of hours service with information provided on the website and answerphone should patients call the practice out of hours.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

Complaints information was displayed in the waiting area and available on the website. Patients we spoke with told us they would know how to make a complaint if they felt the need to do so.

The practice had a robust system in place to investigate concerns, with meetings held to discuss issues arising from complaints and incidents. We reviewed the log of serious incidents and concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning cascaded to staff.

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. We found details of the vision and practice values were part of the practice's statement of purpose. Observing staff and speaking with staff and patients we found the practice clearly demonstrated a commitment to compassion, dignity, respect and equality.

The practice statement of purpose outlined the following aims: 'Our purpose is to provide people registered with the practice with personal health care of high quality and to seek continuous improvement in the health status of the practice population overall. We aim to achieve this by developing and maintaining a happy, sound practice which is responsive to people's need and expectations and which reflects whenever possible the latest advances in primary health care.'

We spoke with 12 members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

The practice had introduced monthly governance meetings. Speaking with five of the partner GPs they expressed the additional benefit to formalising governance in this way, alongside daily informal meetings. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

The practice had a clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of audits the GPs had carried out over the past year. These included an audit of antibiotic use, uptake of the influenza vaccination and end of life care. We saw from clinical audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during team meetings and email correspondence. The end of life care audit was presented to a national audience at the Royal College of General Practitioner Conference in September 2014 as an example of good practice.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. The practice had clearly set out leadership and governance roles among the GP partners, with GPs each taking a lead role in different areas for example training, safeguarding, infection control and end of life care.

We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, or with colleagues as and when required. Staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, a welcome and induction guide for staff, recruitment policy, induction policy and checklist and

Are services well-led?

Good

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

a training policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment Staff we spoke with knew where to find these policies if required. We spoke to a new member of staff and the GP registrars, who were complimentary of the support they had received during their induction.

GPs were actively involved with the Clinical Commissioning Group (CCG) and local neighbourhood groups, with one GP chairing the CCG, another End of life care lead for the CCG. We also noted one GP was the principle investigator for the 'Salford Lung Study' in which they are researching treatment of chronic obstructive pulmonary disease and asthma in Salford.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the National Patient survey, PPG survey, suggestion box, compliments and complaints.

We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 91% of respondents would recommend this surgery to someone new to the area.

The practice had an active patient participation group (PPG) with 27 members. The PPG contained representatives from various population groups; including, older people and working age people. We saw in minutes of meetings the PPG were looking at different ways of recruiting people from minority ethnic groups and young adults to make the PPG more representative.

The PPG met on a monthly basis and the minutes of the meeting were publically available in the waiting area and on the practice website.

The PPG had carried out a survey with patients in March 2014. From the results we saw …. a total of 80 % of respondents rated reception as excellent and 90% found the current opening times of the practice convenient. The results and actions agreed from these surveys were available on the practice website and in the waiting area.

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.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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.

The practice was a GP training practice, with two GP registrars working within the practice. The Lakes Medical Practice is an accredited GP Training Practice by the North Western Deanery of Postgraduate Medical Education. Speaking with the two registrars they were complimentary about the opportunities to learn and the support they received from colleagues at the practice.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and summaries emailed to staff on how the practice could improve outcomes for patients. For example improving the system for providing results to patients over the telephone, following an upheld complaint from a patient.