

St Andrews Medical Practice 2

Quality Report

30 Russell Street
Eccles
Manchester
M30 0NU
Tel: 0161 707 5500
Website: www.standrewsmc.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of St Andrews Medical Practice 2 on 7 October 2014. We found that the provider was performing at a level which led to a ratings judgement of Good.

Our key findings were as follows:

- The practice was safe, staff reported incidents and learning took place. The practice had enough sufficient staff to deliver the service.
- The practice was effective. Services were delivered using evidence based practice.
- The premises was clean and fit for purpose and equipment was available for staff to undertake their duties.

- Staff were caring and compassionate, treated patients with kindness and respect and we saw good examples of care.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice.

The practice was well led, with an accessible and visible management team. Governance systems and processes are in place and there is performance and quality management information available. Quality was high on the practice agenda

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 was safe. Information from NHS England and the Clinical Commissioning Group (CCG) indicated that the practice had a good track record for maintaining patient safety. The management of the practice had ensured that there were safeguarding procedures in place and had taken steps to ensure that staff followed these. Staff had received training in safeguarding children and vulnerable adults.

Patients that we spoke with told us that they felt safe. There were effective medicines management processes in place, arrangements in place to deal with foreseeable emergencies and equipment was checked and maintained. The practice was clean and well-maintained.

Systems were in place to investigate and learn from incidents that occurred within the practice.

Good



Are services effective?

The practice was effective. The care and treatment delivered at the practice was effective and was being considered in line with current published best practice. Patients' needs were consistently met and referrals to secondary care were made in a timely manner.

There were enough qualified, skilled and experienced staff to meet patient's needs. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice was a teaching practice and provided placements for trainee doctors.

Good



Are services caring?

The service delivered by the practice was caring. The patients we spoke with during our inspection, were complimentary about the service and said they were treated with dignity and respect.

They also told us they were involved in making decisions about their treatment and care and were always asked for their consent. We observed examples of good interaction between patients and staff and noted that staff treated patients with respect and kindness and protected their dignity and confidentiality. Staff we spoke with were aware of the importance of providing patients with privacy. Carers or an advocate were involved in helping patients who required support with making decisions.

Good



Summary of findings

Are services responsive to people's needs?

The practice was responsive to patient's needs. There was an open culture within the organisation and a clear complaints policy. The practice responded appropriately to complaints about the service. Regular patient surveys were conducted and the practice took action to make suggested improvements.

The practice participated actively in discussions with commissioners about how to improve services for patients in the area.

We found that the practice had an effective system to ensure that, where needed, the GP could provide a consultation in patient's homes. The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

The service was accessible and responsive to patients' needs. The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter alerting patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was their second language.

Good



Are services well-led?

The practice was well led and effectively responded to changes. There was a strong and visible leadership team with a clear vision and purpose. There was a leadership and management structure in place and staff that we spoke with were clear with whom they could approach with any concerns they might have.

Governance structures were in place and there was a robust system for managing risks. Staff were committed to maintaining and improving standards of care. The team used their clinical audit tools, clinical supervision and staff meetings to assess how well they delivered the service and make improvements.

Good



Summary of findings

What people who use the service say

We spoke with four patients who were using the service on the day of our inspection. The patients were complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect.

The national GP survey results published in July 2014 indicated that the practice was best in the following areas:

- 92% (CCG (regional) average 79%) of respondents would recommend this surgery to someone new to the area.
- 89% (CCG (regional) average 75%) of respondents described their experience of making an appointment as good.
- 79% (CCG (regional) average 66%) of respondents usually wait 15 minutes or less after their appointment time to be seen

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas:

- 73% (CCG (regional) average 86%) of respondents had confidence and trust in the last nurse they saw or spoke to.

- 68% (CCG (regional) average 81%) of respondents say the last nurse they saw or spoke to was good at giving them enough time.
- 70% (CCG (regional) average 80%) of respondents say the last nurse they saw or spoke to was good at listening to them.

Over the last year one comment had been made by a patient on the NHS choices website and this was in respect of their very positive experience of the service.

St Andrews Medical Centre promotes a patient questionnaire annually through the patient participation group (PPG). This questionnaire covers all three practices in the centre and there were 165 respondents who completed the form. The results of this are reviewed by the practice staff and an action plan is formulated. For example only 44% of respondents knew of the website and therefore an action for 2014 was to promote the website to the patient population of all the practices. Also 94.5% of respondents indicated they were seen by a GP or practice nurse within a reasonable timescale and 97.5% felt they were treated with dignity and respect by the GP.

St Andrews Medical Practice 2

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP and a practice manager.

Background to St Andrews Medical Practice 2

St Andrews Medical Practice 2 practice is part of the St Andrews Medical Centre Group. This is composed of three different practices. For the purposes of administration and building management the practices operate as a single group. They work as a group to allow pooling of skills and resources whilst maintaining practice autonomy.

St Andrews Medical Practice 2 has 6684 patients registered and is part of the Salford Clinical Commissioning Group. There are four partner GPs, a practice manager, practice nursing staff, a practice administrator and supporting administration and reception staff. It is a teaching practice and had a trainee GP in post at the time of the inspection. The practice offers a range of services for its patient population. The practice is registered with the CQC as a provider of primary medical services that includes the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

One partner GP is also legally responsible for making sure the practice meets CQC requirements as the registered manager.

The Centre is open from 8am to 6.30am. Patients can book appointments in person, via the phone and online. Patients are able to book appointments online and are also able to order/view repeat prescriptions online. They also allocate emergency GP appointments on the day if required, undertake home visits when necessary and have an out of hours service available provided through the NHS 111 service.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Salford Clinical Commissioning Group (CCG) information showed the practice rated as an achieving practice.

Why we carried out this inspection

We inspected this service as part of our new 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.

This provider had not been inspected before and that was why we included them.

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

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

Before our inspection we carried out an analysis of the data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 07 October 2014.

During our visit we spoke with a range of staff, including GPs, nursing and administrative staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members.

Are services safe?

Our findings

Safe Track Record

Information from the quality and outcomes framework, which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

The practice had a robust complaints policy in place and we reviewed complaints data. We also looked at all accident records and saw that they had all been investigated appropriately.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice kept records of significant events that have occurred and these were made available to us. Significant events were discussed at the weekly practice meeting. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to staff. We saw that all events had been brought to a satisfactory conclusion, and any actions that were implemented as a consequence to prevent recurrence. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

From the review of complaints information we saw that GP partners ensured complainants were given full feedback and asked for detailed information about their concerns. We saw that the practice then checked if the complainant was satisfied with the outcome of the investigations and any actions made to improve the service.

Reliable safety systems and processes including safeguarding

The practice was able to identify the things that were most important to protect patients from abuse and to promote safety. A proactive approach was taken to safeguarding. A GP took the lead role for safeguarding in the practice. There was a practice policy for safeguarding patients in place and these were understood and consistently implemented by staff. This included safeguarding information for children, young people and vulnerable adults. We saw that relevant

safeguarding information and contacts from the local authority were available for staff. The staff we spoke with were aware of these. Staff awareness was underpinned by safeguarding training.

The practice had a chaperone policy in place and this was usually undertaken by one of the nurses or GPs if required. Information for patients about the use of a chaperone was on display in the reception area.

Medicines Management

We checked medicines stored in the treatment rooms and fridges and found that they were managed and stored appropriately. There was a clear policy for maintenance of the cold chain and action to take in the event of a potential failure. We also saw that the temperature of the fridges, used specifically for the storage of medicines and vaccines, were regularly checked and recorded. Cold chain protocols were strictly followed. We saw written records of these and this was confirmed by staff. The “cold chain” is the process of maintaining medicines at a temperature range.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how staff who generate prescriptions were trained, how changes to patients’ repeat medicines were managed and the system for reviewing patient’s repeat medicines to ensure they were still safe and necessary. 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. The practice did not accept prescription requests by telephone.

The practice followed NHS Protect guidance on the security of prescription forms for practice managers and for prescribers. Blank prescriptions were stored securely.

Cleanliness & Infection Control

The practice had a lead for infection control, a practice nurse, who has undertaken infection control training to enable them to provide advice on the practice infection control policy. We also saw that other staff members including GPs had undertaken infection control training.

We saw evidence that they had a recent infection control audit which was completed by the local infection prevention control team. Any improvements identified for

Are services safe?

action were completed on time. We saw evidence that the findings of the audits were discussed at practice meetings. There had been no reported incidents from sharps injuries or spillage. All staff had received induction training about infection control and thereafter regular updates.

There were effective systems in place to reduce the risk and spread of infection. We observed all areas of the practice to be clean, tidy and well-maintained. The consulting and treatment rooms were clean and well maintained with appropriate floor and surface coverings.

We observed good hand washing facilities to promote high standards of hygiene. Instructions about hand hygiene were available throughout the practice with antibacterial hand wash and hand gels in receptions and clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms and in reception. Examination couches were washable, curtains around them were disposable and there was appropriate flooring in treatment areas.

The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. We saw sharps containers that were labelled correctly and not overfilled.

Staff told us that Legionella testing was undertaken by the Centre's landlords, the local Clinical Commissioning Group (CCG).

Equipment

We found that the practice regularly checked and serviced all equipment to ensure its safety and suitability for daily use. The practice manager and GP partners had ensured that all of the clinical equipment used in the practice was regularly calibrated and that staff were competent to use it. We saw records of servicing and calibration for items such as scales, electrocardiogram (ECG) and blood pressure monitors. This ensured readings taken from this equipment were accurate.

We also saw that fire and intruder alarms were regularly tested, checked and serviced. There were also checks of fire extinguishers and portable appliance testing (PAT) of all electronic and electric equipment and appliances.

Staffing & Recruitment

There was a practice recruitment policy in place that followed the principles of The Equality Act 2010, Employment Rights Act 1996, Human Rights Act 1998,

General Medical Services Contracts Regulations 2004 and Personal Medical Services Agreements Regulations 2004. We looked at staff files which showed that staff were provided with training on all the key aspects of their role as part of the induction process. During our inspection we looked at records relating to staff recruitment and induction. We saw records that confirmed that all staff had been through a recruitment process, references were confirmed and they had undergone identity checks prior to starting work at the practice.

There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Monitoring Safety & Responding to Risk

The Practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included risk assessments of the building, the environment and equipment. These were carried out by the building landlords, the local CCG, but monitored by practice staff. Any risks were discussed at GP partners meetings and within practice meetings. For example, the practice had reviewed recent findings from an infection control audit and worked through how to address the recommendations.

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The practice manager told us they were responsible for producing the rota, approving annual leave and for ensuring there were sufficient reception staff on duty each day.

We saw there were sufficient medical and nursing staff were on duty to deal with expected demand including home visits. The practice manager told us this gave additional flexibility to cover vacancies, absences or meet increased demand, for example after a bank holiday.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylactic shock. Staff that would use

Are services safe?

the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest.

Arrangements to deal with emergencies and major incidents

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. We reviewed the practice business continuity plan that confirmed this. This included contingencies in what to do in the event of loss of the surgery building, loss of computer system, loss of access to paper medical records, loss of equipment and utilities. It also had information on what to do if the GP or other member of staff became incapacitated. It also detailed what to do in the event of fire or flood and response to an epidemic/pandemic and response to a major incident. This plan had not been updated for a significant period of time.

We also spoke with staff who knew what to do in case of an emergency. This demonstrated that appropriate action has been taken to deal with medical and other emergencies in a timely and safe manner. There were also risk identification and assessments in place to support the plan that detailed the risks associated with loss of computer systems, personnel, clinical matters and premises. We saw evidence that these were regularly reviewed and updated. There was an annual fire drill and the fire alarms were tested weekly.

Staff we spoke with and records seen, confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained to a minimum of basic life support.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinicians we interviewed were able to describe and demonstrate how they access both guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners.

The clinicians we spoke with were familiar with, and used current best practice guidance. All clinicians we spoke with were aware that it is their own responsibility to stay updated regarding NICE guidelines.

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Practice nurses told us they managed specialist clinical conditions such as diabetes, heart disease and asthma. This meant they were able to focus on specific conditions and provide patients with regular support based on up to date information. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The GP told us this supported all staff to continually review and discuss new best practice guidelines. The practice was a teaching practice and was involved in the vocational training of qualified doctors, registrars, who wish to enter general practice. The registrar works in the centre for a year having completed a minimum of three years working in hospitals. The practice also had close links with Manchester University Medical School. Third and fourth year medical students were attached to the practice for up to 13 weeks. Their work was closely supervised by the GP partners. Feedback from the training was provided annually by the medical school.

We saw that the staff had developed an extremely effective way of monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example the annual health checks and smears.

The practice was knowledgeable about health needs of older patients. They had information on patients' health conditions, carers' information and whether patients

needed home visits. They used this information to provide services in the most appropriate way and in a timely manner. Staff were also able to recognise signs of abuse in older people and knew how to refer these concerns.

Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed.

Management, monitoring and improving outcomes for people

We found that people's care and treatment outcomes were monitored and that the outcomes were compared (benchmarked) against Clinical Commissioning Group (CCG) and national outcomes.

The practice participated in clinical audit and peer review, which led to improvements in clinical care. We saw evidence that the practice acted upon the results of clinical audits, and that they undertook follow up audits to ensure the management and monitoring of services to improve outcomes for patient was effective. The results of audits were shared with the clinical team through practice meetings or via email.

We examined evidence that indicated that the treatment outcomes for the practice were within expected norms and also sustained over time. Information from Quality and Outcome Frameworks (QOF) quality and productivity (QP) indicators supported this. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Effective Staffing

We saw evidence that confirmed that all GPs had undertaken annual appraisals and that they had either been revalidated or had a date for revalidation.

From our review of information about staff training, the induction programme covered a wide range of subjects such as health and safety, confidentiality and equality and diversity. Staff also had access to additional training related to their role. This included such training about as cancer as a long term condition, podiatry training and administering of adrenaline training. We confirmed that staff had the knowledge and skills required to carry out their roles.

Are services effective?

(for example, treatment is effective)

The staff files we reviewed showed that staff of all disciplines received annual appraisal and the clinicians had access to regular clinical supervision sessions. The administrative staff told us they were well supported and regularly had conversations about their performance with their line manager. The practice had procedures in place to support staff in carrying out their work. For example, newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures and meetings with the manager to help confirm they were able to carry out the role. Staff told us they had easy access to a range of policies and procedures on their computers to support them in their work.

The practice manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work. GPs had protected learning time and met with their external appraisers to reflect on their practice, review training needs and identify areas for development.

Working with colleagues and other services

The registered manager, the lead GP, represented the group on the local medical committee and the CCG professional executive committee. The registered manager was also the prescribing lead for the CCG and provided advice to them and local health trusts on prescribing matters.

We found that the practice worked with other service providers to meet people's needs and manage complex cases. There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet patient's needs. Joint working arrangements which allow services to work together were in place and were regularly reviewed.

The practice had a policy for communicating with out of hours and other providers. This was done electronically. Each morning the practice received information from the out of hours service provider, 111, by email about patients who had used this service. This information was reviewed by a GP and notes annotated accordingly.

Referrals were made using the Choose and Book service. We saw the practice had an effective referral process in place..

The practice held multidisciplinary team meeting when needed to discuss the complex needs of patients and those with end of life care needs.

We found the practice worked well with other agencies and health providers to provide support and access specialist help to older people when needed. We found that treatment and care was delivered in line with the patient's needs and circumstances, including their personal expectations, values and choices.

Where older people had complex needs then special patient notes or summary care records were shared with local care services including the out of hours provision. End of life care information was shared with other local services.

The practice was knowledgeable about the health needs of patients with long term conditions. They worked with other health services and agencies to provide appropriate support.

Information Sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved both internal and external to the practice, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Consent to care and treatment

We saw that the GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to and for children and young people Gillick assessments were completed. One of the GPs was the practice lead for the Mental Capacity Act 2005 and they routinely worked with other services in the area to complete capacity assessments and make 'best interest' decisions.

Health Promotion & Prevention

The practice demonstrated a commitment that ensured their patients had information about a healthy lifestyle. This included information about services to support them in doing this. There was a range of information available for patients displayed in the waiting area and on notice boards in the reception areas. This included information on children's health and immunisations, long term conditions such as asthma, information for people who suffer from mental ill health and learning disabilities, and general

Are services effective?

(for example, treatment is effective)

health promotions that included smoking cessation, bowel cancer, diabetes and alcohol awareness. They also provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. Staff we spoke with were knowledgeable about other services and how to access them. During our inspection we saw a local authority health improvement worker promoting the benefits of the flu vaccination with the patients in the waiting area. The health improvement service provided a variety of sessions including weigh in and smoking cessation. They also promoted health checks across all population groups.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible. We saw a new patient joining the practice during our inspection.

The practice worked proactively to promote health and identify those who require extra support, for example those

with long term conditions. There was evidence of appropriate literature and of good outcomes for these areas as demonstrated in the QOF data. Rates for cervical screening were above the national average.

The practice offered a full range of vaccinations for foreign travel. The practice nurse was the lead for this and provided advice and information regarding foreign travel. Appointments for these were made with the practice nurse so that immunisation could be completed.

The practice nurse team also offered a variety of health checks for patients that included blood pressure checks, well woman checks, diabetic reviews and asthma checks. There was a system in place to recall to review which included those patients diagnosed with Chronic obstructive pulmonary disease (COPD), mental ill health, a learning disability, and those that required a repeat Xray.

All patients suffering from a long and enduring mental illness and those with a learning disability were offered a physical health check every twelve months.

Health promotion advice and information was available for people experiencing poor mental health, including people with dementia, which included information about MIND, a mental health charity.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and patient questionnaires completed by 165 patients. The evidence from all these sources, including what the patients said to us on the day of inspection, showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Over the last year one comment had been made by a patient on the NHS choices website and this was in respect of their very positive experience of the service.

St Andrews Medical Centre promoted a patient questionnaire annually through the patient participation group (PPG). This questionnaire covers all three practices in the centre and there were 165 respondents who completed the form. The results of this were reviewed by the practice staff and an action plan was formulated. For example only 44% of respondents knew of the website and therefore an action for 2014 was to promote the website to the patient population of all the practices. Also 94.5% of respondents indicated they were seen by a GP or practice nurse within a reasonable timescale and 97.5% felt they were treated with dignity and respect by the GP.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk in a room to the rear of reception which helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients'

privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the entrance areas and patient reception area stating the practice's zero tolerance policy to any form of violent, aggressive or abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results.

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

Staff told us that translation services through 'Language Empire' were available for patients who's first language was not English. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting areas and patient website also signposted people to a number of support groups and organisations.

The practice had a protocol for carers which detailed appropriate referrals to adult social services and a carer's assessment. This also contained information available for carers to ensure they understood the various avenues of support available to them. The practice's computer system alerted GPs if a patient was also a carer.

Are services caring?

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The NHS Local Area Team (LAT) and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that need to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies, regularly updated shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients who were unable to attend the practice. For example patients who were housebound were identified and referred to the district nursing team to receive their vaccinations.

Each patient contact with a clinician was recorded in the patient's record, including consultations, visits and telephone advice. The practice had a system for transferring and acting on information about patients seen by other doctors and the out of hours service. There was a reliable system to ensure that messages and requests for visits were recorded and that the appropriate doctor or team member received and acted upon them. The practice had a system in place for dealing with any hospital report or investigation results which identified a responsible health professional and ensured that any necessary action was taken. There was a system to ensure the relevant team members were informed about patients nearing the end of their life. There was also a system to alert the out of hours service and duty doctor if somebody was nearing the end of their life at home.

Tackling inequity and promoting equality

The practice provided appropriate access and facilities for patients with disabilities.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment. Staff were knowledgeable about interpreter services for patients where English was their second language.

Access to the service

Patients could access the service via a telephone booking or on line if registered to do so. Urgent cases were seen on the same day. We observed this occurring during our visit. The practice nurse treated patients for a wide range of common conditions and appointments can be booked up to a month ahead.

The national GP survey results published in July 2014 showed that 86% of patients said it was easy to get through to the practice to make an appointment. 92% of patients said they found the receptionist helpful once they were able to speak with them. Patients we spoke with showed that patients did not have difficulties in contacting the practice to book a routine appointment.

When necessary longer appointments were given to older people and home visits had been arranged if necessary.

The practice provided a range of services for patients of working age, including those recently retired and students, to consult with GPs and nurses, including on-line booking and telephone consultations. Patients were also able to book a consultation with a GP through the extended hours service. The appointments system was regularly reviewed to try to maximise timely access to services for this population group.

The building itself was accessible for patients with some limited mobility. All patient, staff and public areas were clean, well maintained and safe.

Listening and learning from concerns & complaints

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

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with knew how to raise concerns or make a complaint. Information on how to complain was displayed in the reception area and in the practice information leaflet. There was also a complaints/suggestion box in the reception area which was checked on a regular basis.

Patients were informed about the right to complain further and how to do so, including providing information about

relevant external complaints procedures. Whilst none of those spoken with had needed to complain, they all said they would be able to talk to the staff if they were unhappy about any aspect of their treatment.

During the last year there were four complaints received by the practice. We noted that all complaints were responded to within agreed timescales and that apologies for any distress that the actions may have caused were passed to the patient.

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. They had a mission statement to provide and deliver general practitioner services to the patients registered at St Andrew's Medical Centre. Their aim is do this to the best of their ability and to the highest possible standards in a caring environment, equitably, efficiently, with optimal accessibility, flexibility and using every human and financial resource available.

Staff we spoke with were knowledgeable about this and they all knew and understood the vision and values and knew what their responsibilities were in relation to these

Governance Arrangements

The GP partners took an active leadership role for overseeing that the systems in place were consistently being used and were effective. For example there were processes in place to frequently review patient and staff satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

Practice staff were clear about what decisions they were required to make, know what they were responsible for as well as being clear about the limits of their authority. It was clear who was responsible for making specific decisions, especially decisions about the provision, safety and adequacy of the care provided at practice level and this was aligned to risk. The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impact on the quality of care.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via paper and computer copies. We looked at a number of these policies and procedures and confirmed most were reviewed annually and were up to date. The ones we looked at included health and safety at work, confidentiality, information systems security, recruitment and the bullying and harassment policy.

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. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The members of staff we spoke with were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example training, support arrangements and recruitment, which were in place to support staff. We were shown the staff handbook that was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

There was a schedule of meetings within the practice. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the practice manager. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

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

The practice had gathered feedback from patients through patient questionnaires and complaints received. We were shown a report on comments from patients which had a common theme of the some of the seating in the waiting are being in a state of disrepair. We saw there was an action plan in place to repair these though the work had not yet started.

The practice had a patient participation group (PPG) which has steadily increased in size and now had 40 members. The PPG conducted the patient questionnaire survey on

Are services well-led?

Good 

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

behalf of the centre. The results and actions of these surveys were available on the practice website. There was no member of the PPG available to speak to us during our visit.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

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 staff files and saw that

regular appraisals took place. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended. We observed that there was a practice meeting with a guest speaker taking place during our inspection.

The practice was a GP training practice and was involved in the vocational training of fully qualified doctors who wish to enter general practice. They also have forged strong links with the Manchester University Medical School and had medical students attached to the practice periodically.

The practice had completed reviews of significant events and other incidents and shared with staff via practice meetings to ensure the practice improved outcomes for patients. For example one patient did not receive information in a timely manner. Therefore they reviewed and modified their automatic distribution of patient documents to prevent recurrence.