John Street Medical Practice

Quality Report

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Date of inspection visit: 17/03/2015
Date of publication: 04/06/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at John Street Medical Practice on 17 March 2015. Overall the practice is rated as good.

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

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a GP and that urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had a predominantly Bangladeshi patient population, the majority of which did not speak English as a first language. 76% of staff spoke at least two languages and there was usually a staff member available who could speak with patients in their own language. This meant staff could explain the importance of tests and treatment to patients.

Summary of findings

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

Importantly the provider should:

- The practice should start to have formal meetings for clinical and reception/administrative staff. Minutes should be kept of these meetings.
- The provider should ensure that all GPs have up to date mandatory training, including safeguarding, basic life support and fire safety.
- Appraisals should be up to date for all staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Appraisals were out of date but plans had been put in place for all staff to have an appraisal during the first half of 2015.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision 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 held regular meetings, although these were not formalised. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was in its inception and the practice were looking for ways to increase membership. Staff had received inductions when they started work. Not all staff had had a recent appraisal but these had been arranged for early 2015.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice had a very low percentage of older patients, but all patients over the age of 75 had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was open until at least 7pm on weekdays, and from 8am until noon every Saturday morning.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability.

The practice had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patient experiencing poor mental health had received an annual physical health check. The practice took this opportunity to carry out any other required health checks, administer vaccinations or give healthcare advice.

Staff had a good understanding in the Mental Capacity Act 2005.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary. Patients could be referred for counselling to nearby services.

Summary of findings

What people who use the service say

We received 36 completed patient comment cards and spoke with eight patients at the time of our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed CQC comments cards were mainly positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their privacy and dignity was maintained. Patients told us they received excellent care in a friendly manner. They said they felt GPs listened to their concerns. The patients we spoke with told us they could always access an emergency appointment when they required one.

The practice's most recent patient survey carried out in February 2015 showed that patients spoke positively of the service

We also looked at the results of the latest national GP survey. The survey results included:

91% of respondents said their last appointment was convenient.

92% said the GP was good as listening to them and 83% said the same of the nurse.

82% of respondents said the receptionists were helpful.

Areas for improvement

Action the service SHOULD take to improve

- The practice should start to have formal meetings for clinical and reception/administrative staff. Minutes should be kept of these meetings.
- The provider should ensure that all GPs have up to date mandatory training, including safeguarding, basic life support and fire safety.
- Appraisals should be up to date for all staff.

Outstanding practice

- The practice had a predominantly Bangladeshi patient population, the majority of which did not speak English as a first language. 76% of staff spoke at least two languages and there was usually a staff member available who could speak with patients in their own language. This meant staff could explain the importance of tests and treatment to patients.

John Street Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and an expert by experience. An expert by experience is someone who has used health and social care services.

Background to John Street Medical Practice

John Street Medical Centre is based on the ground floor of a building in the centre of Oldham. There is a car park available.

GDT Healthcare is the provider. GTD Healthcare is a not-for-profit organisation that has several GP practices, out of hours services and walk in centres in the area. All staff are salaried.

Four GPs and four practice nurses worked at the practice, and a healthcare assistant worked there on one day each week.

The practice is open from 7.45am until 7pm on Mondays and Fridays, 7.45am until 7.15pm on Tuesdays, Wednesdays and Thursdays and from 8am until noon on Saturdays.

The practice delivers commissioned services under an Alternative Provider Medical Services (APMS) contract. At the time of our inspection 3735 patients were registered with the practice. The practice had young patient population and the majority of patients were Bangladeshi and did not speak English as a first language. 76% of staff were bi-lingual.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Detailed findings

- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 March 2015. During our visit we spoke with a range of staff, including a GP, practice nurse, reception staff and members of the management team. We spoke with eight patients attending the practice on the day of our inspection. We reviewed 36 CQC comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. They had received training in the reporting of incidents and were encouraged to report anything out of the ordinary, positive or negative. We saw there was an easy to understand guide for staff to refer to if they had to report an incident. Staff and managers told us that the practice used incidents to promote learning rather than to criticise. Incidents were discussed at the regular informal staff meetings.

There were clear lines of leadership and accountability in respect of how significant incidents, including mistakes were investigated and managed. Before visiting the practice we reviewed a range of information we held about the practice and asked other organisations such as NHS England and Oldham Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. We saw that incident reporting forms were available electronically for all staff. A log was kept of all incidents. Most incident reporting forms were dealt with by the practice manager. Incidents were given a score depending on the severity of the incident and the safety risk to the practice. Staff were aware of the scoring system and at what stage an incident would be referred to the head office to be dealt with.

Learning and improvement from safety incidents

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents that had occurred in the previous 12 months and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the incident being recorded. This included an example of medicines being issued by a pharmacy prior to the date on a prescription. The practice liaised with the pharmacy so systems could be put in place to prevent reoccurrence. The incident reporting forms were designed to generate solutions to issues and ensuring they did not reoccur. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We saw an example of a complaint being made following an incident. We saw evidence this had been fully investigated, with the GP reflecting on their actions and changing a system as a result of the complaint. Some incidents had been used as part of practical teaching scenarios within the practice.

National patient safety alerts were disseminated by the head office to all practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They told us relevant alerts were discussed at practice meetings. The practice meetings held were informal so minutes were not kept. However, it was evident from documents seen during the inspection, such as the outcomes log for incidents, that staff did meet to discuss these areas of work. Plans were in place for significant events to be formally discussed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw the policies in place for the safeguarding of children and vulnerable adults. These provided information about the roles and responsibilities of staff. We looked at training records which showed that the majority of staff had received relevant role specific training on safeguarding. However, one of the GPs had not undergone any safeguarding training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

In October 2014 training on child sexual exploitation had been provided to staff by Greater Manchester Police. We saw that contact numbers for the police were available if staff needed advice on the issue or needed to make a referral. The practice was in the process of arranging training on domestic violence.

Good

Are services safe?

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to the appropriate level (level three). All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy in place. This gave instruction to follow for any staff member who was chaperoning a patient. Staff were trained before they were asked to chaperone patients. Staff we spoke with confirmed they had received training prior to being asked to chaperone a patient. They were aware of the procedure to follow, for example they were aware they must stand inside the curtain while a patient was being examined. A Disclosure and Barring Service (DBS) check had been carried out on all staff who performed chaperone duties.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The temperature of the fridge used to store medicines and vaccinations was checked daily and a log book completed. There was a protocol in place to ensure this check occurred every day including when dedicated staff were absent from work. The fridge had an alarm that sounded if the temperature went outside the required range. Staff were aware of the procedure to follow if this occurred.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry date, and a log was kept to alert staff of when a medicine was approaching its expiry date. Expired and unwanted medicines were disposed of in line with waste regulations. There was a good selection of medicines kept at the practice to use in an emergency. GPs told us they rarely took medicines or injections with them on home visits. They said the practice was in close proximity to the hospital A&E department.

Patients were able to order repeat prescriptions on line or in person, and they were usually ready to collect within 24 hours. More patients were taking advantage of electronic prescribing, so their prescription was sent directly from the practice to the pharmacy of their choice.

We saw that medicine alerts were sent directly to GPs. Following an alert a clinical audit had been completed to look at the appropriateness of certain medicines and staying within the guidelines. Patients requiring repeat prescriptions had a regular medicines review. These were carried out either in person or by telephone. The practice manager monitored medicine reviews and if a patient was overdue a review they intervened and ensured a GP carried out a review immediately.

Cleanliness and infection control

We observed the premises to be visually clean and uncluttered. We saw there were cleaning schedules in place with details of what cleaning should take place on a daily, weekly, monthly and less frequent basis. Cleaning records were kept to confirm the required tasks had been completed. Carpets were deep cleaned every year. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Cleaners attended the practice for three hours each morning Monday to Saturday.

We saw the infection control guidelines that had been updated in January 2015. These included all aspects of infection prevention and control, including hand hygiene, personal protective equipment, waste management, sharps and spillages. The training records we examined showed that the majority of staff had received training in infection prevention and control. However, one of the GPs had not received training. The staff we spoke with were familiar with their responsibilities and knew who to contact for additional advice. The infection control lead was the practice nurse.

We saw evidence that the cleaner was supervised by their company on a regular basis. The practice carried out mini audits on the standard of cleaning and infection control daily and weekly. The CCG had carried out a full infection control audit in January 2015. We saw that an action plan had been put in place to address the minor issues highlighted. A meeting had been arranged with the cleaning manager to discuss these. We saw that the privacy curtains in consultation rooms were disposable and had last been changed 21 January 2015.

We saw that a Legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment had been carried out in July 2012. Following on from this regular tests were carried out, the most recent being 13 March 2015. There was weekly flushing of low use water outlets and a record was kept of this.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. A schedule of testing was in place. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

The practice had a recruitment policy that included the procedure to follow when recruiting clinical and non clinical staff. Following a job offer being made prospective employees were asked to attend the practice bringing in two forms of identification. A Disclosure and Barring Service (DBS) check was carried out and then a start date was arranged. We saw there was a statement on the recruitment of ex-offenders that was followed if a DBS check had an offence recorded.

We looked at a selection of personnel records. Each record contained a checklist to ensure all aspects of the recruitment process had been followed. This included checking a work history had been provided, gaps in employment had been explained, references, including one from the most recent employer had been provided, DBS checks had been received and qualifications and professional registrations had been checked. The records we saw provided evidence that all required checks had been carried out.

The head office had an approved list of locum GPs that could be used. They ensured all the required locum checks, such as qualifications and insurance, had been carried out. If there was no locum on the list available the practice was able to go to a locum agency.

The practice had a safe staffing policy in place. Cover for busy periods was usually arranged internally, but there was the facility for staff within the company to help at other practices. Saturday staffing was organised using a rota and clinicians had set times for the surgeries.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A full risk assessment had been carried out in December 2014 with no major issues being identified. There was a health and safety representative at the practice and meetings were held at head office every three months.

We saw that the oxygen and automatic external defibrillator (AED) were checked weekly to ensure they were ready for use. Emergency medicines were regularly checked and a record of these checks was kept.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received recent training in basic life support.

The practice had oxygen and an automatic external defibrillator (AED) on the premises. These were checked weekly to ensure they were ready for use. Appropriate emergency medicines were available. These were kept securely and at the correct temperature. All the medicines we saw were within their expiry date. We saw that checks were carried out to ensure the emergency medicines were available and in-date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been updated in February 2015. This was very detailed and contained guidance on how to manage events such as loss of power, loss of staff, disputes and epidemics. Information about how to communicate with services was included. The plan was kept at the practice as a hard copy and electronically. The practice manager kept a copy at home, and head office had a system where a manager was on call 24 hours a day so there was someone always available in an emergency.

The practice had carried out a fire risk assessment that included highlighting actions required to maintain fire safety. There were no outstanding actions. Records showed fire alarms, emergency lighting and evacuation routes were checked regularly. Fire extinguishers had an annual service and we saw the next check had been arranged. All staff had been trained in fire safety and there were appointed fire wardens. Staff had also received health and safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), and guidance published by professional and expert bodies We saw that such standards and guidelines were easily accessed electronically by the GP, and they were stored. We saw examples of GPs following NICE guidelines. They disseminated relevant information electronically to other staff within the practice.

The GPs did not take lead roles in specialist clinical areas; responsibility was shared. Staff knew they could approach any GP for advice on any clinical area. Patients with long term conditions, such as chronic obstructive pulmonary disease (COPD) or asthma, were invited for a review of their condition at least once a year. The practice nurses often carried out these reviews, and two had received specialist training in diabetes, asthma and chronic obstructive pulmonary disease (COPD). A register was kept of all patients with a long term condition (almost 17% of the practice population).

All patients over the age of 75 had a named GP. Appropriate care plans were in place for these patients. Patients with mental health needs were invited to attend an annual review. This appointment was used as an opportunity to review all health needs.

Read coding at the practice was used effectively.. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. We saw that clinicians completed patients' records so they could be easily followed by any appropriate person. Consultations, test results and letters were all stored on the computer system to ensure clinicians had all information available to them.

Discussion with GPs and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff conducted consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw evidence of the clinical audits cycles that had been carried out. These included an audit on repeat prescribing requests and another on the use of anti-psychotic medicines for dementia patients. The audit cycles showed there had been a positive outcome for patients. We saw that some audits had been completed and were due to be repeated to check for improvements over time.

We saw evidence of the Quality Outcomes Framework (QOF) being regularly discussed at practice meetings. The status of annual health checks, such as for COPD and asthma, were discussed during these meetings. The practice manager was responsible for inviting patients with long term conditions for a review. Some of these reviews took place with practice nurses who had received appropriate training. Evidence was seen of clinicians referring to the most up to date guidance when reviewing patients' conditions.

The practice had high referral rates to other services or secondary care due to the patient demographics. To monitor this they started a system of peer reviewing all

Good

Are services effective?

(for example, treatment is effective)

referrals to ensure they were appropriate. GPs and other staff communicated with patients in their own language to stress the importance of attending any appointments that were made.

GPs attended Clinical Commissioning Group (CCG) GP meetings to keep up to date with any changes in the area. Nurses also attended similar meetings. The practice had a very low elderly patient population. Patients who required palliative care were discussed during clinical meetings and care packages were put in place. However, this was a rare occurrence. The practice was putting plans in place to set up multi-disciplinary meetings for patients needing palliative care.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice manager kept a record of the training completed for each staff member. We saw that in addition to mandatory training additional training appropriate to the role of the staff member had been arranged. We saw that the majority of staff were up to date with their mandatory training. However, one GP was not up to date with all their training, including basic life support, safeguarding children and fire safety awareness. Staff told us they were able to request additional training if they felt this would enhance their role. All training was requested via the head office who made a decision about the need for training and backfilling staff while training took place. There was no protected learning time at the practice; the contract stated it was not allowed to close for training.

There was an induction programme in place for all new staff. This included corporate induction and an induction for the practice they worked in. All initial training and knowledge of policies was included in the induction training.

There was a system in place so that staff had an annual appraisal with their line manager. Due to staffing difficulties these were not up to date for reception and administrative staff. However, arrangements had been put in place so that appraisals for all staff would be carried out in 2015. The appraisals for nurses were up to date. The staff we spoke with told us they were well supported at work and could approach their line managers if they had any concerns.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. The GPs told us they reviewed the records, took any appropriate action and ensured their patient records were up to date.

The practice had not held any recent formal multi-disciplinary team (MDT) meetings. However, nurses regularly met with community matrons at CCG meetings. There were plans in place to start having formal MDT meetings in the near future. The GPs had regular meetings with other GPs within the CCG.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. They told us referrals were made in a timely manner.

Health trainers attended the practice to give healthy living advice to patients. Other services, such as midwifery and health visitors, were based at nearby centres in the community. The practice was able to contact these services when required. The practice did have a smoking cessation service but this was stopped due to the low uptake. However, there was a service in a nearby health centre and the practice could refer patients there if needed.

Information sharing

The practice used several systems to communicate with other services. When patients were discharged from hospital the practice received a discharge letter

Good

Are services effective?

(for example, treatment is effective)

electronically. When patients had attended the A&E department or the out of hours service, electronic notifications were received by the practice. A fax was sent to the practice by the walk in centre to inform GPs when a patient had attended. GPs reviewed the information and took action as required. If a patient was receiving palliative care GPs at the practice sent a handover fax to the out-of-hours provider to ensure they had the latest information about the patient. Electronic systems were also in place for making referrals.

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

The latest national GP patient survey reflected that 86% of respondents said the GP was good at explaining tests or treatments to them (CCG average 82%), and 87% said the same of the practice nurse (CCG average 76%). Also 79% of respondents said the GP was good at involving them in decisions about their care (CCG average 75%), with 83% saying the same of the practice nurse (CCG average 67%).

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The practice had an up to date consent policy that gave information about different types of consent. This stated the circumstances where consent needed to be in writing, and the procedure to follow if a patient did not have the capacity to consent. In these circumstances a patient's capacity to consent was formally assessed. Best interest decisions were explained. The practice's chaperone policy also gave information about consent and about consent for patients under the age of 16.

The clinical and administrative staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. GPs also told us how they would obtained consent for patients who had, for example, a learning disability. They were aware of who to involve in making the decision and the circumstances where a mental capacity assessment was necessary.

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms then were offered a new patient appointment with a clinician. During this appointment information such as the patient's height, weight, smoking and alcohol consumption status and family history usually were discussed and relevant information recorded. Advice about lifestyle was given.

Patients aged 40 and over were invited for an NHS health check. The practice invited patients for these checks by letter and by telephone. They monitored the uptake rate and had a system in place to identify suitable patients. At the time of our inspection 25% of eligible patients had attended for a health check.

The patients with the highest risk of being admitted to hospital had a care plan in place. The practice manager monitored these and where necessary patients were contacted and offered extra support. We saw that out of 44 patients identified as having a higher risk of an unplanned hospital admission 41 had a care plan in place.

The practice had a system in place to ensure patients eligible for the flu vaccine received these. Clinics had been held for the flu vaccine and the practice provided opportunistic vaccinations if patients attended for other matters. Staff told us they telephoned patients to explain the importance of having the vaccination as they felt this was more effective than writing to them.

The practice monitored the take up rates for vaccinations and other health tests such as cervical smears. Where a patient did not attend an appointment they found that a telephone call from a GP would often persuade a patient to attend their appointment. We saw that 71% of eligible patients had had their flu vaccination, with 13% declining. The measles, mumps and rubella (MMR) vaccination had been given to 86% of eligible patients and there was a high

Good

Are services effective?

(for example, treatment is effective)

take up rate for the shingles vaccine. The practice told us that 82% of eligible patients were up to date with their cervical smear tests and they were working towards a target of 95%.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The patient survey showed that 89% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 83%) and 92% thought their GP was good at listening to them (CCG average 88%). The figures when asked the same about the nurse were 81% (CCG average 91%) and 83% (CCG average 79%). The survey showed that 82% of patients found the receptionists helpful (CCG average 86%), 90% thought the GP gave them enough time (CCG average 84%), and 82% thought the same of the nurse (CCG average 88%). The practice carried out their own satisfaction survey in February 2015 and the majority of respondents rated the helpfulness of reception staff as 'excellent'. Some reception staff had completed a national qualification in customer care.

The patients we spoke with gave us positive comments about the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. The patients we spoke with told us they were given enough time during their appointments and the GPs and nurses listened to them. We reviewed 36 CQC patient comments cards. The majority of these gave positive comments about the practice. They commented they were treated with respect by staff who were friendly, helpful, listened to them and treated them with respect.

Seven of the eight patients we spoke with told us they had enough privacy at the reception desk, with one patient telling us they would prefer to have a cubicle to ensure conversations weren't overheard. Staff told us there was a private room available if a patient requested a more private conversation. Patients told us they were able to request to see a GP of a specific gender although sometimes an on the day appointment with a specific GP could not be arranged. They told us they were offered a chaperone during examinations when this was appropriate.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided around couches in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. The chaperone policy stated that patients must be given privacy when undressing. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The latest GP patient survey information showed 79% of patients felt the GP was good at involving them in decisions about their care (CCG average 75%), with 83% saying the same of the nurse (CCG average 67%). The survey showed that 86% of patients thought the GP was good at explaining tests and treatments (CCG average 82%) and 87% said the same of the nurse (CCG average 76%). The majority of the patients we spoke with told us the GPs and practice nurses explained tests and treatment to them and they felt they were listened to. Most said they were given options about their treatment where this was available. The CQC comments cards we reviewed also provided evidence of patients being listened to with no concerns being highlighted about people's involvement in their care planning.

The practice population was predominantly Bangladeshi, with the majority not speaking English as a first language. However, 76% of staff spoke at least two languages and there was usually a staff member available who could act as an interpreter for patients. This was particularly helpful when telephoning patients to arrange appointments and explain the importance of attending some health checks. The practice used an interpreter service when necessary.

Patient/carer support to cope emotionally with care and treatment

Counselling services were available within the CCG area. GPs were able to refer patients for appointments near-by. Patients were able to self-refer to a talking therapy service, but staff told us there was a long waiting list. Specific bereavement counselling was available in the area. Most of the patients we spoke to told us they had not required emotional support. One patient told us how they had been supported by the practice following bereavement. They said that if they needed any help they were able to call into the practice for advice, and they felt the practice were very helpful and supportive. We saw that an information pack was available to give patients practical advice about what to do following bereavement, and also give them information about support groups.

Good

Are services caring?

The practice provided information to carers about support groups in the area. The practice kept carers register so appropriate advice and consideration could be given to carers when they attended. Carers were easily identifiable from the computer system.

The provider held a staff well-being forum for staff working in their group of practices and other services. This was to ensure the health and well-being of staff, but also promote a culture of understanding.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

GPs did not take lead clinical roles, but shared responsibility for long term conditions. Nurses did have key roles, including a lead nurse for asthma, diabetes, children's health and chronic obstructive pulmonary disease (COPD). There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate intervals for patients who required regular medicines.

The practice kept a register of patients with a learning disability. They were invited for an annual health check. Patients with mental health needs also had an annual review with a GP, and the GP attended their other health needs at this time if required. The practice computer system had a facility to alert the clinician when a patient attended and other needs were due to be considered at the same time.

All patients over the age of 75 were given a named GP. However, the practice had a young patient population, with 87.2% of patients being under the age of 50. Care plans were in place for patients with a higher risk of an unplanned hospital admission. The practice did not currently hold multi-disciplinary team (MDT) meetings but there were plans in place for these to start.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice served a predominantly Bangladeshi population. The majority of patients did not speak English as a first language, with many not speaking any English at all. Most GPs, and 76% of all staff, spoke at least two languages. There was usually a staff member at the practice who was able to speak with a patient in their own language. Staff were not usually used to translate during patient consultations with clinicians. However, they were able to communicate well with patients either in person or over the telephone, to explain aspects of the practice or the importance of attending for certain health checks and appointments. A telephone translation service could be used and the practice also had access to interpreters when required.

The practice provided equality and diversity training through e-learning, repeated every two years. Most of the staff we spoke with confirmed that they were up to date with this training.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was fully accessible for patients using a wheelchair, or with a pushchair and consultation rooms were all on the ground floor. There was a hearing loop in place for patients with hearing difficulties. There was an accessible toilet.

The practice manager told us there were no homeless patients registered at the practice. However, they had a good understanding of the difficulties faced by homeless patients trying to access a GP and they knew the process to follow so homeless patients could access GP and other services.

Access to the service

We spoke with eight patients during our inspection. All of these had telephoned the practice on the morning of the inspection and been given an emergency appointment. Patients told us it was easy to make an emergency appointment, and children were always seen if an appointment was requested. One patient commented that being able to speak in their own language with a staff member made the appointments process much easier. We reviewed 36 CQC comments cards and only one commented that they found it difficult to access appointments. The results of the latest national GP patient survey showed that 63% of patients found it easy to get through to the practice on the telephone (CCG average 69%) and 91% said their last appointment was convenient. The practice's own patient satisfaction survey, carried out in February 2015, showed that of the 59 patients who responded to the question about the length of time they needed to wait to access an appointment, 26 rated it as 'excellent' and 25 as 'very good' or 'good'. We checked the appointments available on the morning of our inspection. We saw the next available routine appointment was in four days' time, and the next emergency appointment was available the same day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice manager explained the appointments system to us. Routine appointments could be made, online or by telephone, up to two months in advance. Patients could ring at any time of the day and request an urgent appointment. Patients requesting an urgent appointment had a telephone triage call from a GP and then an appointment was made if necessary. The practice also had appointments available for patients who had been redirected to the practice by the A&E department. The practice manager told us they were able to accommodate all patients who needed an urgent appointment.

The practice was open between 7.45am and 7pm Mondays and Fridays, 7.45am to 7.15pm Tuesdays, Wednesdays and Thursdays and 8am until noon on Saturdays. Patients who worked, or younger patients in education, were therefore able to access appointments outside the normal working day.

There were 36 housebound patients registered at the practice. Staff told us that visits were arranged for these patients when they needed to see a clinician and clinicians arranged to carry out health checks and give vaccinations in the patient's home.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy, dated January 2014, and procedures, dated May 2012, were in line with recognised guidance and contractual obligations for GPs in England. They contained very detailed instructions, including the need to monitor the NHS Choices website and respond to any negative comments. The practice manager was responsible for managing complaints within the practice and head office supported them. The head office signed off complaint responses and monitored them to see if there were any recurring themes. GPs were only involved if the complaint directly related to them.

We looked at the four complaints that had been raised in the 12 months prior to our inspection. None of these had been upheld. The complaints had been investigated and responses made in accordance with the policy. We saw that on occasions verbal complaints were recorded. The practice manager told us that not all verbal complaints were recorded; it depended if they could be easily resolved or not. However, they told us there were plans to log all verbal complaints in the near future.

Staff knew how to advise patients to make a complaint. They told us that complaints were discussed during meetings and if there were areas highlighted where learning was required this was communicated during meetings.

Information about how to complain was readily available at the practice. When required, leaflets could be printed in different languages.

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. The vision and values were communicated to staff during their induction training. It actively promoted a learning culture. The staff we spoke with were aware of the values of the provider and felt part of the wider team.

We spoke with staff who told us they knew what their responsibilities were in relation to maintaining the values of the provider. Although formal recorded meetings had not taken place recently staff told us the informal meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. All the staff we spoke with were aware of each other's responsibilities. The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place. These were managed by the provider from the head office.

There was a head office management team in place to oversee the systems, ensuring they were consistent and effective. The management team covered all the practices run by the provider. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role. They met on a regular basis, and had regular contact with staff at the practice.

We saw that the provider managed staffing issues. This meant that staff from other services run by the provider could be shared between services. This had worked well during the recent maternity leave of one member of staff. We saw that succession planning was in place and this had been particularly effective whilst planning the retirement of a practice nurse. The nurse had given more than the required notice period to ensure the role was fully covered.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. The GPs told us that although they did not have formal meetings they met informally on a regular basis and they felt they were kept well informed of relevant issues by the provider. We spoke with staff members and they 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.

Meetings for reception and administrative staff were also informal. The last meeting where minutes had been recorded took place in August 2014. Although the meetings and minutes were not kept staff told us they were used to disseminate any relevant information to staff and give them the opportunity to ask any questions. Staff told us the practice manager had an open door policy and was very approachable, as were the GPs.

Seeking and acting on feedback from patients, public and staff

The practice carried out patient satisfaction surveys. The most recent survey had been carried out in February 2015. This particularly focussed on assessing patients' satisfaction with accessing appointments. The majority of responses were very positive. We saw evidence that the practice had discussed the results in a meeting arranged for the patient participation group (PPG) but this had not been well attended. There were plans in place to circulate the results more widely.

The practice had recently tried to set up a PPG. Patients had been invited to join the PPG verbally, and formal invitations had also been given to random patients. The first meeting had been held on 6 March 2015, where it had been intended to discuss the recent patient satisfaction survey. Only one patient attended. The practice were holding a PPG awareness week in June 2015 to try to increase numbers. They had also tried to set up a virtual PPG, where members were communicated with by email. They hoped to attract younger patients by using technology. However, patients had not responded to their request. The practice manager told us there was a comments and suggestions box in the reception area but this was very rarely used.

Are services well-led?

Good

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

The practice had been using the friends and family test since it started in December 2014. We looked at the results from 1 December 2014 until 4 March 2015 and the results were positive. The majority of patients said they would be likely to recommend the service.

The staff we spoke with told us the practice manager had an open door policy and they were encouraged to make suggestions about how the service could be improved. There were opportunities to put forward their ideas during the regular informal meetings.

Management lead through learning and improvement

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. Staff told us they were supported in their personal development.

We saw evidence that the continuing professional development (CPD) of the practice nurse was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

Although appraisals for nurses and GPs took place, the practice was behind with appraisals for administrative and reception staff. Plans were in place for these to take place during 2015, and most dates had already been arranged for the first half of the year.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved.