Kapur Family Care

Quality Report

Werneth Primary Care Centre
Featherstall Road South
Oldham
Lancashire
OL9 7AY
Tel: 0161 4841414
Website: www.kapurfamilycare.nhs.uk

Date of inspection visit: 19th March 2015
Date of publication: 21/05/2015

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 Kapur Family Care on 19th March 2015. Overall the practice is rated as good.

They were good for providing safe, effective, caring, responsive and well led services and also good for providing services to 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 further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should :

- The practice should implement a mechanism to store national safety alerts and clinical updates so they have a record to refer back to of those received and actioned.

Summary of findings

- The practice should ensure there are specific arrangements for patients with hearing problems in keeping with current guidance and good practice.

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. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff met regularly with multidisciplinary teams to discuss complex patient care. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. Further training needs had been identified and training was planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. The CQC intelligent monitoring data showed that results from patient feedback on questions about caring services were higher in all aspects than the national average. 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 the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff understood their responsibilities in relation to it. 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 governance meetings. 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 active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP and care plans have been completed where necessary.

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. There was a named GP responsible for each long term condition and all coding of conditions and diseases were completed by the GPs. The practice nurse held a variety of clinics and was proactive with recall, monitoring and review. 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. For those people with the most complex needs, the nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

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 proactive in offering online services and text messaging as well as a full range of health promotion and screening that reflects the needs for this age group. Late night surgeries were available and appointments could be booked in advance.

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. It had carried out annual health checks for people with a learning disability and provided care plans where necessary. It offered longer appointments for people with a learning disability.

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

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). The lead GP had an interest in dementia and mental health. All patients were on the appropriate registers and were invited for annual health checks and medicine reviews. Patients were encouraged to use the services provided such as the local Link Centre and Age UK. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. All staff had completed dementia awareness training.

Summary of findings

What people who use the service say

We spoke with four patients and reviewed comments from 25 Care Quality Commission (CQC) comments cards which had been completed. None of the comments were negative. Patients spoke highly of all the staff and in particular praised the receptionists for their kindness and patience. Comments included praise for the GPs who were said to be thoughtful, thorough and good at putting patients at ease.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. They were satisfied with the cleanliness of the environment and the facilities available. They were happy with access to the building which suited the needs of patients with wheelchairs and prams.

We reviewed the results from the latest GP Survey where 120 responses out of 453 questionnaires issued were received. The practice scored higher than the local CCG average in the following three aspects :

79% of respondents with a preferred GP usually got to see or speak to that GP - Local (CCG) average: 58%

80% of respondents found it easy to get through to this surgery by phone - Local (CCG) average: 70%

77% of respondents described their experience of making an appointment as good - Local (CCG) average: 70%

In addition, 96% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

- The practice should implement a mechanism to store national safety alerts and clinical updates so they have a record to refer back to of those received and actioned.
- The practice should ensure there are specific arrangements for patients with hearing problems in keeping with current guidance and good practice.

Kapur Family Care

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 advisor and a practice manager specialist adviser as well as an expert by experience. An expert by experience is someone who has used health and social care.

Background to Kapur Family Care

Kapur Family Care is currently a three partner practice providing continuity of care for all ages. It has been a practice since 1994 when two single handed practices merged. It moved to the current purpose built medical centre in 2011. The lead GP has been with the practice since 1994 and there is a stable workforce of long standing nursing and administration staff. They serve a diverse population of 5,400 patients in an area with a deprivation score of 41.5. They cover the areas of Coppice, Hollins, Werneth, Westwood and Chadderton districts of Oldham. At least 50% of the population are of Asian ethnicity and there is a high percentage of patients under the age of 18 years.

The building complies with the Disability Discrimination Act 1995 (DDA). All consulting rooms are on the ground floor with corridors and doors wide enough for wheelchairs. Car parking is available on site. The practice offer an open list and welcome new patients living or moving to the area.

Medical staff include a lead female GP and two male partner GPs who provide 22 clinical sessions a week. There is also a female GP trainee.

Services offered include chronic disease management, childhood vaccinations, six week baby assessments, travel vaccinations, extended hour surgeries, smoking cessation services and drug dependency and counselling services.

The practice is open 8am until 8.30pm on Mondays, 7.30am until 6.30pm on Wednesdays and 8am until 6.30pm on Tuesdays, Thursdays and Fridays. There are dedicated practice nurse and nurse assistant clinics daily. Appointments can be made online via the practice website or by telephone or calling in to the surgery. Emergency appointments are available daily.

The practice have opted out of providing services to their own patients out of hours. Information on how to access out-of-hours services is available on the practice website, in patient leaflets and over the telephone.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008. 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.

There were no previous performance issues or concerns about this practice prior to our inspection.

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:

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19th March 2015. During our visit we spoke with the three GP partners, the practice manager and three reception/administration staff. We also spoke with the nursing staff. We talked to four patients, the chairman of the patient participation group and reviewed 25 CQC comments cards. As well as speaking to people we observed staff throughout the day to see how they cared for patients.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety such as reported incidents, national patient safety alerts, feedback from staff and comments and complaints received from patients. There was a lead GP responsible for incident reporting and staff were aware of their responsibilities to raise concerns. They knew how to report incidents and near misses. Forms were completed electronically and sent to the practice manager. Incidents such as medication errors or patients missing vaccination appointments had been recorded.

We looked at the significant event logs and incident reports for the previous two years and reviewed minutes of some of the meetings where these were discussed. We saw that the practice had managed these consistently over time which evidenced a safe track record over the long term.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at the accident book which had only needed to be used twice in the previous twelve months and the accidents recorded were minor.

Sixty significant events had been recorded and we looked at five that had occurred during the last twelve months. One of those showed that the practice became aware of a child who had not been invited for their eight week check up and had not received their appropriate immunisations. Following this a system was implemented, that all clinicians seeing children under the age of five checked their immunisation status and stored the information on the patient's electronic record. This, and other events we reviewed, showed that the practice dealt with events appropriately, shared learning and implemented changes to lessen the chance of reoccurrence in the future.

Significant events were a standing item for discussion at practice meetings and we reviewed minutes from several meetings which were all listed by date and easily located for future reference. Staff also attended primary health care team meetings and half day education sessions where significant events were discussed.

Staff spoken with said that incidents were reported to the practice manager, or any one of the GPs, and all were electronically recorded using specific forms available to staff on the desktops of their computers.

National patient safety alerts and other clinical updates received were dealt with by the GP responsible for that day. They decided if the matter needed to be discussed that day or could wait until the next practice meeting. Some examples of alerts relevant to the care staff were responsible for were provided but these related to alerts from some time ago. There was no formal mechanism to scan alerts or guidance on to the computer system which meant there was no record of those received or dealt with.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a policy for the safeguarding of children and vulnerable adults with instructions to staff on recognising the different forms of abuse and contact telephone numbers of responsible agencies. There was a lead GP with overall responsibility and all three GPs had done online level three safeguard training. The lead GP had attended two external training days in paediatrics and elderly safeguarding. The other GPs and GP registrar had also attended external face to face safeguard training and practice nurses were trained to the appropriate level 2.

We looked at training records which showed that all administration staff had received relevant role specific training on safeguarding. The practice manager was trained to level two. All staff knew who the lead was and understood how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to raise concerns, share information and record documentation. The GP registrar had a portfolio showing reflection on safeguarding issues.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments such as children subject to child protection plans. A significant event evidenced where this system had been put in to practice.

There was a chaperone policy in place. Male GPs would generally pass intimate examinations of female patients to

Are services safe?

female GPs if the patient preferred and a female GP was available for the requested appointment. Where this was not possible the nurses were asked to prepare and chaperone the patient during the examination. Male patients were also asked if they would like a chaperone. Reception staff were used to chaperone when required and all had completed e-learning in November 2013. Staff spoken with were aware of their responsibilities, where to stand and how to record information.

Medicines management

The practice had a robust medicine management system in place. All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. GPs used the review system on the electronic patient record for all patients and review intervals differed dependant on the nature of the medication and age of the patient. All patients were reviewed at least six-to-twelve monthly.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. 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 dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was training as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. This had a positive impact in the management of patients with long term conditions who did not now need to wait for a GP to sign a prescription.

Medicine management was discussed at practice meetings. The Oldham Medicine Management Team (OMMT) attended the practice regularly and informed them of any Medicines and Healthcare Products Regulatory Agency (MHRA) alerts. The OMMT would pro-actively search the patient register and inform the practice of any action required.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The testing and investigation of legionella to reduce the risk of infection to staff and patients, was organised by the NHS property and building management company who were responsible for all aspects of the building. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed this.

Equipment

Are services safe?

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 and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales, spirometers, blood pressure measuring devices, couches and fridges. Any breaks were reported to the building managers and recorded as incidents.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non clinical staff. The practice manager was responsible for all human resources and elements of recruitment. We reviewed staff records which showed that appropriate recruitment checks had been undertaken prior to employment. These included proof of identity, references, qualifications and registration with the appropriate professional bodies. Checks were undertaken by the practice manager to ensure registrations were kept up to date and records we looked at evidence that they were. Disclosure and Barring Service (DBS) checks were undertaken for medical, nursing and administration staff and we saw them in the staff records we looked at.

Arrangements for planning and monitoring the number and mix of staff was the responsibility of the practice manager and we saw that staff were arranged to meet the needs of the practice and its patients. There was a rota in place and staff were able to cover each other's roles when required. The practice manager and a senior receptionist were trained and received required safeguarding training o measure and weigh babies when they came for their six or eight week checks and immunisations. This helped to reduce pressure on the GPs and nurses and speed up the process for the patients.

One of the practice nurses was undertaking a prescribing course to meet patients' needs when managing chronic and long term conditions and this also reduced pressure on the GPs and sped up the process for patients receiving prescriptions.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment carried out by the practice manager. Previous assessments we looked at evidenced that action had been taken to resolve identified risks. No risks had been identified at the last assessment undertaken in February 2015.

The practice also had a health and safety policy folder with a smaller diluted electronic version available to staff on their computer desktops. The practice manager was the identified health and safety representative. Identified risks on the risk log within the health and safety file had been discussed with staff when appropriate.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice building manager had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. An evacuation had recently been undertaken and reception staff in particular were aware of what to do in the event of fire. There were dedicated fire marshals within each of the three practices in the building.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Each computer had an emergency button to summon help and there were also emergency pull-cords in the consulting rooms. We were told of an incident where it had been necessary to use the alarm but staff had not known what to do when they heard it. Following this incident the centre manager was arranging training for all staff within the building so that everyone knew what to do

in the event of it happening again. In the meantime the practice had implemented its own protocol and staff were all aware of it. Training scenarios to deal with emergencies were regularly undertaken.

All staff had received on line training in basic life support at least within the last twelve months and face to face training was arranged for March 2015. CPR and anaphylaxis (severe allergic reaction) was included in this training. Four non clinical staff were already anaphylaxis trained. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Maintenance and checking of the oxygen was shared with another practice within the building.

Emergency, 'on-the-day' appointments were available and appointments had been set aside for patients who inappropriately attended the accident and emergency department. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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. These systems made certain that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. The GPs and nursing staff were able to explain their approaches to treatment which followed current best practice guidance from organisations such as the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed with required actions agreed. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs which were reviewed when appropriate.

GPs led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used the Choose and Book system to make routine referrals and whilst waiting for the appointment patient's treatment would be monitored and any interim care required was provided. They also checked and followed up that patients received their referral appointments.

All GPs we spoke with used national standards for referrals. Oldham Clinical Commissioning Group (CCG) have eight clusters who share prescribing and referral information at cluster meetings every month. The practice used these meetings for peer review and to learn from each other. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

We looked at seven clinical audits that had been undertaken in the last twelve months. The GPs told us that all had been re-audited and the cycle completed but some had not yet been formally written up. We saw three full completed audit cycles. One in particular was a large audit on the care of patients with chronic obstructive pulmonary disorder (COPD). It looked at the medicines the patients were taking versus the category they fell in to and patients were called in for a medicine review if they were not receiving the prescription appropriate to their category. This was a large project and the practice was able to evidence that the outcome for patients with COPD was improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw several audits of medicines which had been undertaken due to the input of the Oldham Medicines Management Team. An example was making sure that antibiotic prescribing was in line with guidelines for conditions such as ear and urine infections. We saw completed analysis on this.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they

Are services effective?

(for example, treatment is effective)

continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors who held lead roles in areas such as training, mental health, dementia, depression and the management of chronic disease. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, such as a nurse who was being trained as a prescriber. As the practice was a training practice, doctors who were training to be qualified as GPs were allocated extended patient appointments and had access to a senior GP throughout the day for support. They also had a one-to-one educational day with the lead GP once a week. We received positive feedback from the trainee we spoke with.

Practice nurses performed defined duties and were trained to the appropriate levels. The nurse we spoke with was responsible for COPD, diabetes, asthma, and smears. Another nurse was responsible for bloods and injections. The nurses had their own supervisory forum within the practice and were supported by the medical and admin staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP for the day who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for several new enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The services included Drug Misuse, Disease-modifying antirheumatic drugs (DMARDs) (These are a group of medications commonly used in patients with rheumatoid arthritis, monitoring), minor surgery, extended hours, travel clinics and chlamydia screening. They were also involved in Clinical Commissioning Group (CCG) schemes such as having care plans in place for all patients over the age of 75, separate care plans for patients in Nursing and Residential Homes and all patients discharged from hospital to be reviewed either at surgery or at home after one week. They also pro-actively assessed frail and elderly patients to reduce falls. We saw evidence of positive impact on patients' outcomes under these schemes.

The practice held meetings monthly with the primary health care team and also attended cluster meetings monthly with eight other practices. Complex cases and ways to improve outcomes for patients were discussed. Monthly meetings took place with Macmillan nurses, district nurses, health visitors and the practice team and patients on end of life care or complex needs were discussed at these meetings. We reviewed minutes from these meetings which evidenced discussions and actions required. Staff spoken with felt the meetings were a good means of sharing important information and creating positive outcomes for patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely

Are services effective?

(for example, treatment is effective)

manner. Patients being sent to accident and emergency were given a typed letter or a summary to take with them. In some cases the GP made a telephone call to the receiving department before the patient was sent.

The practice had signed up to the electronic Summary Care Record and patients had been offered the opportunity to opt out. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

There were systems in place so that staff had access to the information they needed. There was an electronic patient record used to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

There was a practice policy which explained the different types of consent such as implied or expressed, and it set out guidelines on how to obtain and document consent and when this should be done. There was nothing in the policy about the Mental Capacity Act or the Children's Acts 1898 and 2004. However when we spoke with staff we found they understood the term mental capacity and their duties in relation to it. No formal Mental Capacity Act training had been undergone by any staff. The lead GP recognised this as a learning need and had done e-learning on the subject. She had also done some personal research and was using it as one of the things to achieve in her PDP for the next year's appraisal. She was aware of the need for knowledge in this subject in connection with a particular patient where deprivation of liberty may be relevant.

Staff were aware of both Gillick and Fraser competencies in relation to helping children make informed consent. Some members of staff had undergone e-learning in consent and dementia awareness. Two non clinical staff had also completed learning difficulty awareness. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. We saw care plans in place for two patients with advanced instructions on how they wished to be dealt with and do not attempt cardio-pulmonary resuscitation wishes (DNACPR) clearly documented.

Health promotion and prevention

The practice offered health checks to all patients over the age of 40 and these were carried out by the practice nurse. All patients over the age of 75 also received annual health checks as part of their care. The practice manager monitored the uptake of these health checks and carried out recalls for patients who did not attend. Any complications such as high cholesterol, blood pressure risk factors and high glucose results were referred to the GPs for early intervention to prevent or reduce the impact of illnesses such as heart failure or diabetes. The lead GP and one of the other partners had undertaken awareness in problems associated with cancer and looked out for related conditions.

Patients who needed additional support were monitored and offered extra help and advice. An example showed where a patient with mild obstructive airway disease was supported through education, self-management advice and treatment plans. There was a positive reduction in their exacerbation rate which reduced from four episodes in the initial 12 months to zero in the previous 12 months.

The practice uptake rate for cervical smears was up to over 80% and patients were monitored and recalled if they missed appointments. The practice offered advice on smoking cessation, lifestyle and diet and signposted patients to other services when required, such as the smoking service in Oldham.

There were television screens in the waiting rooms which promoted health prevention and a few leaflets in reception with information about access to other services in the area. The practice were not responsible for the building and were unable to display any notice boards or health information of their choice. However the practice website provided an A-Z page of health related conditions and treatment and signposting to other services where advice could be obtained.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from the national GP patient survey 2015 showed that this practice scored higher in some areas than other practices in the Clinical Commissioning Group (CCG). 79% of respondents with a preferred GP usually got to see or speak to that GP – the local average was 58%. 96% had confidence and trust in the last GP they saw or spoke to.

Consulting rooms were private, privacy was maintained in the waiting areas and staff followed confidentiality. Staff told us that 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.

Patients we spoke with said they felt the practice offered a good service and was efficient, helpful and caring. They said they were treated with dignity and respect. Administration and reception staff had completed training in conflict resolution and equality and diversity. We were told this training gave them a better understanding of patients' differences, helped them to understand patient issues and how best to help them.

There were arrangements in place for non-English speaking patients. One of the GPs spoke the Asian languages easily. For East European patients, formal face-to-face interpreters were offered which happened approximately once a month. The practice also had access to language line which was only used occasionally. There were no specific arrangements for patients with hearing problems which was not in keeping with current guidance. We spoke to the GPs about this on the day of inspection.

Care planning and involvement in decisions about care and treatment

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

Care plans were in place for a number of patients with long term conditions such as chronic obstructive pulmonary disorder (COPD), diabetes and asthma. They had completed care plans for 5% of the over 75s population and patients with a tendency to require hospital admission. Patients were involved in the care planning process and offered a paper copy of their plan to take away with them. Nurses and GPs were involved in the implementation, update and review of plans and discussions with patients led to agreement on how to achieve a good outcome. We saw five case studies where positive outcomes had been achieved.

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. 93% felt the GP explained their treatment well and 87% felt involved in the decision making process.

Patient/carer support to cope emotionally with care and treatment

Data from the national patient survey showed 97% had confidence and trust in the last nurse they saw or spoke to and 95% the nurse was good at treating them with care and concern.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown an example where the GP had offered the opportunity of respite care to a parent of a child being cared for. The GP then went on to arrange the respite for the patient. A carer support group had been requested to attend one of the patient participation group (PPG) meetings.

Patients who had suffered bereavement were seen by their usual GP wherever possible and could be referred to a bereavement counselling service. We were given an example where bereavement counselling had been arranged for one family member initially and then later for others.

All the GPs had undergone face to face training in dementia and one of the GPs had an interest in mental health. From speaking to the GPs we established that they were able to recognise anxiety and depression in patients with multi-morbidities. The practice had a high population of patients under the age of 18 and staff offered emotional support to parents and their children when required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address any identified patient need and change the way services were delivered. We were told that the practice engaged regularly with the NHS England Area Team, Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that could be prioritised.

Systems in place such as registers, Quality Outcome Frameworks (QOF) and surveys showed that the practice were responsive to patients' needs. The practice had changed their appointment system to try to improve access. Due to a number of complaints and negative responses about the new system the practice reverted back to the old system which patients found more effective.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A recent survey evidenced that text messaging would be helpful to patients. A new system enabled patients to register to receive text appointment reminders and test results by text. Access had also been changed so that patients could book appointments and request repeat medicines online if they wished to do so. These new services were tested by volunteers of the PPG before they were implemented to all practice patients to ensure they were effective.

The PPG for this practice had been established for four years and had regular meetings every six-eight weeks. Minutes of these meeting were available on the website and they were attended by the group representatives and the GPs. They helped to bring patient and GP perspective together and discussed things going on in the community and what they could get involved in to help the patients of the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was a large patient population of under 18s (60%) and a diverse ethnic population. There was a higher prevalence of diabetes compared with the national average and the practice had been pro-active in their treatment of patients with this condition.

The practice had access to online and telephone translation services and a GP who was fluent in the different languages required. Face to face interpreters were used when required. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The premises and services met the needs of patient with disabilities. The building was managed by an NHS LIFT company (a building and management service provided by the NHS) and was not the responsibility of the practices which used it which could sometimes have a negative impact on the practice and its patients. For example the practice were unable to display notice boards.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open 8am until 8.30pm on Mondays, 7.30am until 6.30pm on Wednesdays and 8am until 6.30pm on Tuesdays, Thursdays and Fridays. There were dedicated practice nurse and nurse assistant clinics available at various times every day. A child health clinic was available on a Thursday between 11.00am and 1pm. Appointments could be made online via 'patient access' or by calling the practice between 8.30am and 6.30pm. They could also be made face to face at the surgery.

Routine appointments were available within two working days and emergency appointments available daily. The first five morning and the last three evening appointments for each GP were pre-bookable up to two weeks in advance. All other appointments became available the day before. Home visits were undertaken at the discretion of the GP if a patient was too ill to attend surgery and each GP was responsible for visits to nursing homes and other routine home visits.

Are services responsive to people's needs?

(for example, to feedback?)

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day. The appointment system had been adjusted by the practice to suit the needs of the patients as much as possible. The practice were unable to open the premises outside normal hours or at weekends and required special permission from the building manager for late opening and Saturday flu clinics.

Listening and learning from concerns and complaints

There was a complaints policy and complaints information in the practice leaflet and on the practice website. Patients were encouraged to make comments or suggestions and a suggestion box was provided in the main waiting area. The practice operated a procedure to deal with any complaints received which were handled by the practice manager in the first instance. The complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England.

We looked at complaints received in the last 12 months and found that they handled appropriately and dealt with in a timely way with openness and transparency. Patients were offered an apology when necessary. We saw that the practice changed its practice where they could when the complaint or comment affected the patient majority.

Are services well-led?

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

Our findings

Vision and strategy

The vision and value of the practice was clearly set out in their Statement of Purpose and on the practice website. The practice aimed to treat all patients and staff with dignity and respect at all times and promote good health and well being to their patients through education and information. The GPs shared decision making with staff and engaged in management support.

We were told that the lead GP's vision was to deliver individualised care which was tailored to the population and to be proactive in training the next generation. These aspirations were discussed at meetings with all staff who were encouraged to emulate them. We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its 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 monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. They also mentored and supervised the health care assistant at the practice.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The nursing staff were also involved in clinical audit and the practice nurse had recently undertaken an audit on patients with diabetes which had identified patients with pre-diabetes symptoms who could be referred to early intervention.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff were encouraged to put their views forward and had good relationships with each other. All staff had been at the practice for a number of years and they shared a close, open and transparent working relationship.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of recruitment policies which included action to be taken in the event of disciplinary procedures, the management of sickness and induction. A whistleblowing policy encouraged staff to raise concerns.

The practice organised a monthly training afternoon where the Clinical Commissioning Group CCG put on training sessions or provided a speaker to attend the practice. Clinicians all met regularly to do updates in things such as respiratory medicine and staff regularly socialised together.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group PPG which had increased in size and had been in situ for four years. There were currently 10 members, six male and four female ranging in age from 21-75. They were mixed in employment status and ethnicity and they were continually trying to engage patients in the younger age range, specifically between the ages of 16 and 24. To further support the PPG there was a virtual Patient Reference Group (PRG). These patients were communicated with electronically and currently there were 38 patients in the group with one member acting as spokesperson for a further 21 elderly or inform residents that lived in a local nursing home.

The practice had gathered feedback from patients through the PPG , PPG surveys, suggestions and complaints and the friends and family test. We looked at the results of the

Are services well-led?

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

annual patient survey and 80% said they found it easy to get through on the telephone. Patients agreed that text messaging would be useful and as a result of this the practice had introduced that service.

The practice also gathered feedback from staff through meetings and monthly training afternoons. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and/or management. One member of staff told us how she had requested additional training and had been supported in this. The practice manager told us of another staff member who wanted to progress and who was being supported in additional training.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice. The lead GP wanted to be instrumental in the training of the next generation of general practitioners. We saw the GP trainee in surgery on the day of the inspection. They were given longer appointments with patients and were supported by the lead GP. They were able to access that support whenever needed and also had regularly one-to-one sessions where their clinical practice was discussed and assessed.

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