St George's Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of St Georges Medical Centre on the 9 June 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- There were systems in place to protect patients from avoidable harm, such as from the risks associated with medicines and infection control. Equipment used by staff was checked for its safety. The practice had systems in place for reporting, recording and monitoring safety incidents.
- Patients' care needs were assessed and care and treatment was in line with best practice national guidelines. Staff were proactive in promoting patients' good health. The practice nurse's annual leave was not always covered by agency staff, rather their work was divided up between other clinical staff. This impacted on patients' care as we were informed patients raised concerns about this.
- Most patients spoken with confirmed they were always treated with dignity and respect and clinical staff explained their treatments and they listened to what they had to say. The practice manager acted as a non-clinical cancer champion to ensure a smooth care package. Some patients raised concerns about the reception staff who they described as rude and unhelpful.
- Quality and performance were monitored, risks were identified and managed. Staff told us they could raise concerns and felt listened to and well supported. Patients were generally dissatisfied with the appointments system and found it difficult to book an appointment. Only half of the patients spoken with said they knew how to make a complaint. The complaint procedure was not displayed in the patient waiting area.

Summary of findings

- The practice vision was to deliver high quality care and promote good outcomes for patients. Meetings took place to share information and look at where service improvements were needed. Training was provided to support staff with their professional development.

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

The provider should:

- The provider should offer patients a chaperone when they have personal examinations.
- The provider should provide information about who patients should contact if they have a concern about the safety of another adult or child.
- The provider should ensure effective staffing levels are provided when nursing cover is unavailable.
- The provider should ensure patients can access appointments with a GP more easily.
- The provider should provide information about who patients can contact for medical assistance when the practice is closed.
- The provider should offer patients information about how to make a complaint.

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 were aware of procedures for reporting significant events and safeguarding patients from the risk of abuse. There were clear processes in place to investigate and act upon any incident and to share learning with staff to mitigate future risk. There were appropriate systems in place to protect patients from the risks associated with medicines and infection control. Health and safety checks were carried out such as fire safety. Staff told us they had the necessary medical equipment such as blood pressure monitors to carry out their work. This equipment was tested and maintained regularly.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' care needs were assessed and care and treatment was considered in line with best practice national guidelines. There was good communication between staff who said they felt appropriately supported. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatments they needed. The practice monitored its performance and had systems in place to improve outcomes for patients. The practice worked with other health and social care services to promote patient care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring and helpful. Some patients reported they found some of the reception staff rude and unhelpful. Patients told us they were involved in planning and making decisions about their care and treatment. Staff were aware of the importance of providing patients with privacy. Patients were provided with support to enable them to cope emotionally with their care and treatments.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice planned its services to meet the differing needs of patients. They monitored the service to identify patient needs and service improvements that needed to be prioritised. Access to the service was monitored to ensure it met patients' needs. The practice had a complaints policy which provided staff with guidance about how to handle a complaint. Most patients confirmed they could get to see

Summary of findings

the same GP when needed. All of the patients told us they had enough time during their consultation to talk about their issues. Some patients told us they found it difficult to book an appointment. This was also reflected in the CQC comment cards. Other patients said they found it easy to book an appointment including an urgent appointment.

Are services well-led?

Good

The practice is rated as good for providing well led services. There was a leadership structure in place. Quality and performance were monitored. Staff told us they could raise concerns and they were well supported. We were informed the practice had experienced some pressures on the service over the past year due to not being able to employ a permanent locum GP to cover a GP vacancy. This had resulted in patients raising concerns about the treatments they received and staff attitudes. The National GP Patient Survey indicated that 57.8% of patients said they would recommend this surgery to someone new to the area. The national average is 78%. It was anticipated the recruitment of two new GPs would address patient concerns as this would bring some consistency to the service.

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. Patients had a named and accountable GP to ensure consistency of care. Patients over 75 years of age had health checks. A care plan was in place for patients who attended hospital outside of a planned admission. Home visits were available for older people from the GP, health care assistant, nurse and phlebotomist. Where it was identified that a patient was vulnerable, their care needs were discussed during multi-disciplinary team meetings to ensure information about them was shared for the purpose of monitoring their welfare. Pre booked appointments were available to patients over 75 years of age; these could be booked one month in advance. Influenza and pneumococcal vaccine clinics were held.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. A system of appointment recall was in place for patients with long term conditions. Dietary advice was given to patients with long term conditions along with lifestyle advice about how to manage their conditions in order to live as healthily as possible. A named and accountable GP was appointed to each patient and a care plan was drawn up as needed. Patients with chronic obstructive pulmonary disease were given medicines to keep at home which they could use at the onset of any symptoms. Influenza and pneumococcal vaccine clinics were held. Systems were in place to identify patients with outstanding test results. This system prioritised the patients with the most long term medical conditions, and also the patients that did not attend for screening, or annual reviews.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Child health surveillance was in place and children under the age of five years were seen by a clinician on the day they contacted the practice or had contact with a GP by phone. Appointments were available before and after school hours. The Human papilloma virus (HPV) vaccine was available along with intranasal flu vaccines. Chlamydia screening was available for patients under 25 years of age and also over this age.

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). Appointments were available from 8am five days a week with late night appointments up to 8pm available on Mondays and Thursdays. This made it more convenient for working age patients to access the service without having to take time off work. A well woman clinic was provided along with travel vaccines. Cardiovascular disease risk assessments were completed with patients between the ages of 40 and 74 years. Information was available to patients about how to give up smoking.

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. Multi-disciplinary team meetings took place with active case managers who supported vulnerable patients who lived alone in the community and had complex medical conditions. A register of vulnerable patients was in place and an alert message was noted on their computer records to ensure quick access to appointments and extra time with clinicians allocated. Care plans were written up if needed. If vulnerable patients did not attend appointments at the practice or in secondary care, case managers were notified. Late night appointments were available up to 8pm on a Monday and Thursday evening for vulnerable patients who may need to be accompanied by a carer who was at work.

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). All patients with pre-existing medical conditions received an annual review and testing of their condition. Arrangements were made with the pharmacy to have medication pre dispensed into daily containers to make it easier and safer to handle. A care plan was in place for patients with mental health problems and dementia. Details of a patient's carer were recorded along with details of their community psychiatric nurse. This ensured that information about the patient was shared with other health care professionals to keep them fully informed of the patient's current health care needs. Double appointments were available so the patient had more time to talk about their health care issues. Patients had a named accountable GP which provides consistency with care provision.

Summary of findings

What people who use the service say

We looked at 34 CQC comment cards that patients had completed prior to the inspection and spoke with 11 patients, five over the telephone and six in face to face interviews.

Patients spoken with were generally very positive about the care they received. They commented that they were treated with respect and dignity and described staff as wonderful, pleasant and very good. Some patients found the reception staff rude. Patients spoken with told us they had enough time to discuss their care needs during consultations and that clinical staff explained their treatments and the risks involved. They said they felt listened to and involved in decisions about their care. Some patients commented they found it easy to make an appointment, although others said they found it difficult to book an appointment. They said they found it particularly difficult to book an appointment over the phone as all appointments had been booked when they got to speak with a receptionist.

The comments on the cards provided by CQC were complimentary about the staff and the service provided. They described the staff as welcoming, cheerful and efficient. Patients commented that they were treated with respect and the GPs were very caring. They indicated they were given time to talk about their treatments and the clinicians listened to what they had to say. Overall they were very happy with the standard of care and treatment they received.

The National GP Patient Survey contains aggregated data collected from January-March 2014 and July-September 2014. The GP Patient Survey was published on 8 January 2015.

68.2%% of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care. The national average is 74.6%.

58.6% of respondents to the GP patient survey stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care. The national average is 66.2%.

75.5% of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. The national average is 82.7 53. %

68.4% of respondents to the GP patient survey stated that they always or almost always got to see or speak to the GP they prefer. The national average is 53.5 %

62.1% find the receptionists at this surgery helpful. The national average is 86.9%.

Areas for improvement

Action the service SHOULD take to improve

- The provider should offer patients a chaperone when they have personal examinations.
- The provider should provide information about who patients should contact if they have a concern about the safety of another adult or child.
- The provider should ensure effective staffing levels are provided when nursing cover is unavailable.
- The provider should ensure patients can access appointments with a GP more easily.
- The provider should provide information about who patients can contact for medical assistance when the practice is closed.
- The provider should offer patients information about how to make a complaint.

St George's Medical Centre

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, a specialist advisor with management experience and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services.

Background to St George's Medical Centre

St Georges Medical Practice is based in Bury, Greater Manchester. The practice treats patients of all ages and provides a range of medical services. The staff team includes a GP partner, and three salaried GP positions. Two of the salaried GP posts are currently vacant and being covered by locum GPs. There is one practice nurse, two part time healthcare assistants and a part time phlebotomist. The administration team consists of the practice manager, and seven administration and reception staff.

The practice did not have a website although we were informed this issue was currently being addressed. Information about the practice could be found on the NHS choices website. Appointments were available from 8am to 6pm on Mondays and Fridays and from 8am to 8pm on Tuesdays and Thursday. On Wednesdays appointments were available from 8am to 1pm.

General enquires were taken after 10am. Patients could book appointments in person or by phone. The practice provides telephone consultations, pre bookable consultations, same day (advanced access) appointments and home visits to patients who are housebound or too ill to attend the practice. The practice closes one afternoon per month for staff training. No information was available about who patients should contact if they need medical care out of hours.

The practice is part of North Manchester Clinical Commissioning Group. It is responsible for providing primary care services to 7095 patients. The practice has a Primary Medical Services contract.

Why we carried out this inspection

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

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

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 9 June 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how staff handled patient information, spoke to six patients in face to face interviews and carried out five telephone interviews. We reviewed a variety of documents used by the practice to run the service. We looked at survey results and reviewed CQC comment cards left for us on the day of our inspection. We spoke with the GP partner, a salaried GP and a locum GP. We also spoke with the practice manager, practice nurse and reception staff on duty.

Good

Are services safe?

Our findings

North Manchester Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service.

Staff told us they completed incident reports and carried out significant event analysis (SEA) in order to reflect on their practice and identify any training or policy changes. Staff spoken with, both clinical and non-clinical told us they felt able to report significant events and that these incidents were analysed, learning points identified and changes to practice were made as a result of this. We looked at a sample of significant event reports and saw that a plan of action had been formulated following analysis of the incidents. SEAs were reported to the Clinical Commissioning Group so they were informed about the operation of the practice.

Medical alerts and safety notifications from national safety bodies were managed by the practice manager and shared with clinical staff during meetings. For example an alert was received about the use of a glucometer. An audit was carried out to monitor patients' safety and to check whether any patients were using this equipment. The outcome of this audit revealed no patients were using this equipment.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. Significant incidents were investigated within the practice by a GP who was not involved in the incident. The findings of the incident were recorded. Lessons were learned and improvements made when things went wrong. Medication was prescribed under NICE guidelines. A significant event had occurred when an error was identified for one patient. A butran patch was prescribed in the wrong dose, this was immediately identified and the error was rectified. This work demonstrated that patients were treated with accordance with best national guidance and that staff were fully informed of the outcome of any safety related investigations for the purpose of learning and improving service provision. Staff were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally.

Reliable safety systems and processes including safeguarding

Information about a chaperone service was displayed in the clinical consultation rooms but not in the patient waiting area. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were informed that only clinical staff acted as a chaperone. They were trained for this role and had completed a Disclosure and Barring Service check to ensure they were suitable to undertake this responsibility. Patients spoken with said they had never been offered a chaperone while having personal examinations. Patients spoken with said they felt safe while visiting the practice.

No information was available in the patient waiting area about what patients should do if they had a concern about the safety of another adult or child.

Staff were trained in safeguarding procedures and during discussion demonstrated the type of things they would look out for when patients visited the practice. For example the practice nurse told us they were vigilant in monitoring children's weight and noting when parents did not attend immunisation clinics. They knew to report safeguarding concerns to the lead GP and the social services safeguarding team.

One of the GPs took responsibility for managing safeguarding issues. They were trained to the appropriate level (level 3) which ensured safeguarding matters were managed correctly and patients were protected from the risk of harm. All doctors were trained to level 3 with the exception of one GP. Level 3 safeguarding training for this GP has been arranged.

A copy of the whistleblowing policy was displayed in the staff room. Staff demonstrated an understanding of this issue and knew they could report their concerns to outside agencies.

Medicines management

Temperature sensitive medicines were stored in a fridge which was kept locked. A policy was available to staff about what they should do in the event of an electrical failure. The fridge's electrical safety had been checked. A record of the fridge temperature and room temperature was kept and monitored. A weekly check was made of the fridge

contents and monthly checks were carried out on vaccine stocks and temperatures. A record of these checks was kept which meant staff could ensure any identified problems had been addressed.

Guidelines were in place for the administration of vaccines and staff were trained on how to administer vaccines. A weekly log of the vaccines used and remaining stock was in place. There were two named staff responsible for ordering, receiving and taking care of vaccines. Vaccines were stored securely and the fridges were only used to store vaccines. We were informed the vaccine fridge had two thermometers to monitor the maximum and minimum temperatures, however one of the thermometers was not in place on the day of our visit. Out of date medicines were disposed of.

Handwritten and printer prescriptions were stored securely. GPs used the General Medical Council guidelines for prescribing medicines. Patients told us they were happy with the way repeat prescriptions were managed although a few patients said their prescriptions were never ready on time.

Cleanliness and infection control

All areas of the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean when they visited. Patient feedback on the CQC comment cards we received was positive about the standard of cleanliness throughout the building.

The practice nurse took responsibility for managing infection control. The practice nurse demonstrated a good understanding of her role and took her responsibilities very seriously. Staff were trained in infection control procedures and a policy was available for guidance. This meant that appropriate measures had been taken to ensure patients and staff were being protected from the potential spread of infection.

Treatment rooms had the necessary hand washing facilities and personal protective equipment such as gloves were available. Hand gels for patients were available throughout the building. Sharps boxes were available for the disposal of needles. Sharps bins were appropriately located and labelled. The practice had spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal.

Equipment

All electrical equipment was checked to ensure it was safe to use. Small portable electrical appliances such as kettles, printers and computers were checked for safety. We checked a number of these items and noted they had all been tested. There were service contracts in place for regular checks of fire extinguishers and the calibration of medical equipment such as blood pressure monitors, baby scales and ear syringes. Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They confirmed that all equipment was tested and maintained regularly.

Staffing and recruitment

There were arrangements in place for members of administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

We looked at a selection of staff recruitment files. We saw evidence that appropriate recruitment checks had been undertaken prior to staff being employed, for example, staff references had been sought along with a criminal records check through the Disclosure and Barring Service. Training certificates had been obtained and confirmation of registration with the appropriate professional body. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There had been few changes to the practice staff team over recent years and the GPs and other members of staff took the lead in respect of a range of clinical and non-clinical areas. This meant patients were being treated by an appropriately recruited staff team who were able to provide a safe, consistent and appropriate service.

Monitoring safety and responding to risk

The practice manager was responsible for compliance with fire safety and other health and

safety regulations for the premises. All new employees working in the building were given induction information

Good

Are services safe?

for the building which covered health and safety and fire safety. There was a health and safety policy available for all staff. The staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. Checks had been completed on all staff to ensure they were suitable to work with patients and a staff disciplinary procedure was in place to manage staff that were no longer suitable to work at the practice.

Arrangements to deal with emergencies and major incidents

Emergency drugs were kept at the practice, these were checked every month with a record of the check being kept and signed. A member of staff told us they had completed training on how to deal with patients who presented with challenging behaviours and further training was being provided in the next few months.

Emergency medicines were held securely and routinely checked by a designated nurse to ensure they were in date and suitable for use. Staff told us they had received training in dealing with medical emergencies including cardiopulmonary resuscitation. A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following loss of building, loss of computer and electrical equipment and loss of utilities. Key contact numbers were included for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw evidence that patients' treatments were effectively assessed with appropriate referrals for secondary care being made. There was evidence of multi-disciplinary working to ensure patients received the right treatments to support good quality care for good health and recovery.

We saw evidence that GPs worked within the National Institute for Health and Care Excellence guidelines and that patients' care and treatments were assessed and planned according to good medical practice.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The practice took part in palliative care meetings and discussed those patients on the Gold Standard Framework to ensure they received the treatment and support needed as a matter of priority.

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 medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two full clinical audits that had been undertaken in the last years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We saw evidence that one related to the poor uptake of childhood vaccination and another about inappropriate prescribing of non-steroidal anti-inflammatory medication. There were systems in place to ensure the outcomes from clinical audits were shared amongst all clinical staff.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify where improvements were needed and to take action. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed 'similar to expected' in maintaining a register for patients with a learning disability, a register of all patients in need of palliative care/support and having regular multidisciplinary reviews of patients on the palliative care register.

The GPs and practice nurse had key roles in monitoring and improving outcomes for patients. These roles included monitoring long term conditions, safeguarding patients from the risk of harm and abuse and monitoring patients who needed palliative care. Multi-disciplinary team and palliative care meetings were held monthly where patient care was reviewed to ensure they were receiving the support they required. These meetings included the district nursing team, community matrons, health visiting team and Macmillan services

Effective staffing

GPs gave us a different opinion about whether there were enough clinical staff. One GP considered there were enough; however another felt there were insufficient clinical staff, although they considered patients' needs were not compromised as this was compensated by appointing locum GPs. A recent recruitment drive had been successful in employing two new GPs, one male and one female. They will begin working at the practice in July and August this year. This will address the issue of patients wanting to see a female GP when the current female GP is on holiday.

We were told that nursing cover was not provided when the practice nurse was on holiday and that patients complained about this. During their holidays their work was divided amongst other staff.

We discussed GP peer supervision; clinical supervision and appraisal and revalidation. The GP annual appraisals and revalidation were up to date. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Evidence of appraisal and revalidation were in place. One GP was appraised in December 2014 and revalidated in 2014. Another GP's appraisal was completed in March 2014. Their revalidation was not yet completed as this works on a 5 year cycle. GPs indemnity insurance was in place.

Staff were offered an annual appraisal of their work to review their performance and identify development needs for the coming year. We spoke with the practice nurse who

Good

Are services effective?

(for example, treatment is effective)

told us the practice was supportive of their learning needs. They said they had received an appraisal in the last 12 months. The practice nurse had access to the Practice Nurse Forum each month and also to clinical supervision with a Practice Nurse Champion. Protected learning time was in place, although one staff member reported they had to complete some training at home in order to keep up to date with developments.

On line training was provided for all staff. A staff training analysis had been completed with each staff member to identify their training needs. Reception staff spoken with told us they felt well supported in their roles. They said they had undertaken the training needed for their roles.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients. Staff described how the practice provided the 'out of hours' service with information, to support, for example patients in need of 'end of life care.' There were processes in place to ensure that information received from other agencies, such as A&E or hospital outpatient departments were read and actioned in a timely manner. There were systems in place to manage blood result information and to respond to any concerns identified. There was also a system in place to identify patients at risk of unplanned hospital admissions and to follow up the healthcare needs of these patients.

Multi-disciplinary team and palliative care meetings were held on a regular basis. Clinical staff met with health visitors, district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify where further support may be required.

GPs were invited to attend reviews of patients with mental health needs. The practice worked with mental health services to review care with specialist teams.

Information sharing

Systems were in place to ensure information about patients was shared with the appropriate members of staff. Individual clinical cases were analysed at informal meetings between clinicians. The practice held regular Gold Standard Framework meetings for patients who were receiving palliative care. The practice shared information in these meeting with other health care professionals such as community nurses and matrons The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance over a weekend. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues and alerts were in place if a patient was a carer. The patients spoken with told us they contacted the practice for their test results. They said the information about test results was available in a timely manner and commented that if there was a problem, they would be informed by letter.

Consent to care and treatment

Clinical staff 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). The practice nurse told us that verbal consent was given following an explanation of treatments being carried out, a record of this was kept on the patient's notes. The practice nurse told us they had completed training on the Mental Capacity Act. They understood that a guardian could make decisions for patients who were unable to make decisions for themselves. We saw evidence of family members being involved in decision making for patients who were unable to give consent to treatments.

Most patients spoken with said the clinical staff obtained their consent before treatments were given. Some patients said this was not applicable to them and some told us they were not aware they could change their mind when a decision about their treatments had been made.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients in leaflets in the waiting area about the services available. Information about advocacy services was also available. Clinics provided at the practice included a well-baby clinic and a well woman clinic and advice around how to stop smoking. Daily clinics were run for cardiovascular illness and diabetes. Opportunistic screening was used for patients who were identified as needing extra support. Half of the patients we spoke with told us they were given information from the nurse about how to manage their health.

Good

Are services effective?

(for example, treatment is effective)

Data from the Quality Outcome Framework (QOF) indicated that childhood vaccinations uptake was below the national average. To address this poor vaccination uptake, the practice had stated vaccinating children opportunistically and during the well women clinic when mothers and young children were present together.

The practice monitored how it performed in relation to health promotion. It used the information from QOF and other sources to identify where improvements were needed and to take action. QOF information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, providing other preventative health checks/screening of patients with physical and/or mental health conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Most patients spoken with said they found the staff to be pleasant and helpful although some said they found the reception staff rude with a couple commenting that reception staff thought they were doctors. This was also commented on in a couple of the CQC comment cards. We discussed this with the practice manager who explained that on occasion, reception staff asked patients details of their conditions to ensure they were directed to the correct clinician, for example, some patients may need to see the practice nurse rather than a GP. The practice manager told us they would address this issue as they did not wish to give patients the wrong impression.

Most patients spoken with confirmed they were always treated with dignity and respect by clinical and non-clinical staff. They commented clinical staff gave very good care and they felt well looked after. Two patients felt they were not treated with respect. We observed staff speaking respectfully and quietly with patients when they visited the practice.

Care planning and involvement in decisions about care and treatment

Most of the patients spoken to with long term conditions confirmed they received follow up appointments to monitor their conditions. Two patients said they did not receive a follow up appointment.

The patient waiting area was very small and most of the patients we spoke with said their conversations with the receptionist could be overheard. There was a separate booth at the end of the reception desk which patients could use and which provided some degree of privacy. A separate room would be made available to patients who wished to speak to staff in private. Most patients said they were not aware this facility was available.

We asked patients whether they were given treatment options during their consultations. We received a mixed response to this question. Some patients told us they were given different treatment options, other said they trusted their GP and took their advice.

Most patients spoken with said the clinical staff explained their treatments and they listened to what they had to say. This was also commented on in the CQC comment cards. One patient told us the clinical staff listened to what they had to say but didn't always explain the treatments.

Patients who had been referred for other care or treatments confirmed this was done in a timely manner although they did not always discuss the treatment options.

Patient/carer support to cope emotionally with care and treatment

Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included information about Mencap and drug and alcohol services. The GPs and the practice nurse referred patients on to counselling services for emotional support, for example following bereavement. Arrangements were made with the pharmacy to have medication in pre dispensed packs in order to make it easier and safer to handle. Details were kept of a patient's community psychiatric nurse. This meant information about the patient could be shared to ensure all health care professionals were fully informed of their current health care needs. Double appointments were available to patients with emotional care needs as necessary so they had more time to discuss their health care issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice manager acted as a non-clinical cancer champion. Their role was to ensure a smooth care package and a point of contact in the practice. The patients were contacted by telephone within one week of their diagnosis and given details about what this service involved. For example, advice was given on prescriptions and booking appointments and support available with different health care professionals.

Prescription could be ordered by telephone and were completed on the same day, ready for collection or faxed to a pharmacy.

A Patient Participation Group was not currently in place. The practice manager had tried to recruit new members for this group by displaying information in the patient waiting area; however they had received no response. The practice manager planned to speak with patients directly about whether they would be interested in becoming a part of this group in order to work with the practice staff to look at ways of improving the service provision.

Tackling inequity and promoting equality

There was ramped access and handrails leading up to the building to support patients who had difficulty with their mobility. A disabled toilet was available along with a hearing loop. There were no baby changing facilities.

Staff were knowledgeable about interpreter services for patients whose first language was not English. Information about interpreting services was available in the waiting area.

Patients' electronic records contained alerts for staff regarding patients requiring additional assistance in order to ensure the length of the appointment was appropriate. For example, if a patient had a learning disability then a double appointment was offered to ensure there was sufficient time for their consultation.

Annual health reviews were carried out in a patient's home if required and in accordance with their needs.

Access to the service

The practice did not have a website although we were informed this issue was currently being addressed. Information about the practice could be found on the NHS choices website. Appointments were available from 8am to 6pm on Mondays and Fridays and from 8am to 8pm on Tuesdays and Thursday. On Wednesdays appointments were available from 8am to 1pm.

General Enquires were taken after 10.00am. No information was available to patients about who they should contact for medical assistance when the practice was closed. Longer appointments were available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to patients who were unable to get to the practice due to poor health.

Patients were generally dissatisfied with the appointments system and found it difficult to book an appointment. This was also commented on in the CQC comment cards although some patients said they found it easy to book an appointment including an urgent appointment. The practice manager informed us this matter was being monitored and a new telephone line was being set up so patients could access the practice more easily in order to book an appointment. The National GP Patient Survey in March 2014 found that 38.5% found it easy to get through to this surgery by phone. The national average is 71.8%.

Most patients confirmed they could get to see the same GP when needed. All of the patients told us they had enough time during their consultation to talk about their issues.

Listening and learning from concerns and complaints

Only half of the patients spoken with said they knew how to make a complaint. We noted the complaint procedure was not displayed in the patient waiting area. The practice had a system in place for handling complaints and concerns. One of the GP partners was responsible for the management of complaints, with the practice manager being the designated contact person. Staff we spoke with were knowledgeable about the policy and the procedures for patients to make a complaint.

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 vision was to deliver high quality care and promote good outcomes for patients. The practice Statement of Purpose recorded the practice aims and objectives of which one was 'To provide a quality service to our patients within a safe and confidential environment'. Patients were complimentary about the service provided. Some patients described the service as excellent. Patients commented that they were always treated with respect. Patients had mixed views about the reception staff. Some said they were friendly; others described them as rude and unhelpful.

The practice had identified areas for the future planning of the business. This included providing further training in conjunction with the local Clinical Commissioning Group, improve patients' access to appointments, address the concerns raised about reception staff and strengthen the practice business plan to reflect the recent recruitment of two new GPs.

Governance arrangements

Staff had specific roles within the practice, for example safeguarding and infection control. The practice manager managed all the administration and support services. The practice had practice specific policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included health and safety and infection control. All the policies were regularly reviewed.

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for staff training. The clinical staff met to review complex patient needs and keep up to date with best practice guidelines. The GP partner and practice manager met several times a week to look at the overall operation of the service.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GP partner showed improvements had been made to the operation of the service and to patient care as a result of the audits undertaken. We discussed the Quality Outcome Framework data (2013/2014) held by the CQC which indicated that the practice was operating below average when compared to the national average in some areas of treatments. For example, treatments related to diabetes care and the uptake of cervical screening. We were informed by the practice manager that this issue was due to poor coding carried out by locum GPs who had worked at the practice over the past year. They told us they were confident that more recent data would present more favourably when compared to the national average.

We were informed the practice had experienced some pressures on the service over the past year as a result of being unable to employ a permanent locum GP to cover a GP vacancy. This had resulted in patients raising concerns about their treatments and staff attitudes.

The National GP Patient Survey indicated that 57.8% of patients said they would recommend this surgery to someone new to the area. The national average is 78%. We were informed that this matter would be addressed through the recruitment of two new GPs who were due to start work in July and August 2015. The GP partner told us they anticipated this would address the patient concerns as it would bring some consistency to the service. They explained they planned to develop the service by allocating specific areas of treatments to individual GPs so these areas could be further developed to improve outcomes for patients.

Leadership, openness and transparency

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. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff spoken with knew where to find these policies if required. A whistle blowing policy and procedure was available and staff spoken with were aware of the process to follow if they had concerns about the way patients were being treated and wanted to report these concerns anonymously.

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

The practice had gathered feedback from patients through clinical audits, in house patient surveys and complaints received. This highlighted where improvements needed to be made and how they were being addressed by the

Are services well-led?

Good

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

practice. For example a new telephone system was being introduced which meant patients would be able to access the surgery more easily to book an appointment. Half of the patients we spoke with told us they had been asked for their views of the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular staff appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of their training needs and they had access to on line training. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made.

The practice had received a silver award from Manchester University for their role in supporting medical students.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training.