St Chads Medical Practice

Quality Report

St Chads Medical Practice
St Chads Centre
Lime Green Parade
Lime Green
Oldham
Lancashire
Tel: 0161 620 1611
Website: www.stchadsmedicalpractice.co.uk

Date of inspection visit: 17 March 2015
Date of publication: 30/04/2015

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 St Chads Medical Practice on 17 March 2015

Overall the practice is rated as good. We found the practice provided safe, well-led, effective, caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had a vision which was patient focussed. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We also saw areas of outstanding practice:

- The practice had implemented frailty assessments for elderly patients.
- The practice had invested in their health care assistant (HCA) training and had given them the opportunity to

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enhance their role beyond usual boundaries. The HCA visited the elderly in their own home to assist in reducing the isolation of housebound patients and making sure their medicines are up to date.
- All new patients to the practice under the age of 5 years were discussed with the health visitor and school nurse to ascertain if they were known to services to allow the practice to support the patients fully.
- The practice had direct access to the electronic system used by their Out of Hours service which allowed them to add any changes to patient's conditions as they happened.

However there were areas where the provider should:

- Ensure the first aider has updated training in the near future.
- Ensure their clinical staff have access to appropriate uniforms for their roles.
- Ensure senior non clinical staff have access to mentorship to allow them to effectively fulfil their roles.

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. The practice had systems in place for monitoring safety and learning from incidents and safety alerts to prevent reoccurrences. For example the practice carried out significant event audits to help clinician and practice based learning. All staff had received safeguarding training and staff we spoke with were aware of the safeguarding vulnerable adults and children policies in place. The practice had a GP lead and nurse for safeguarding who liaised with other agencies when necessary.

There were systems in place to ensure medication including vaccines, were stored correctly and in date.

The practice was clean and tidy. All equipment was regularly maintained to ensure it was safe to use. The practice had emergency medication available including oxygen.

Are services effective?

Good

The practice is rated as good for providing effective services. We found systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Local Clinical Commissioning Group (CCG) data showed that the practice was performing highly when compared to neighbouring practices in the CCG.

Management of risk and information relating to safety was monitored.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients we spoke with and who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had identified the need to improve access to the appointments system and the telephone system. However patients said they found it easy to make an appointment with a named GP, once they had got through on the telephone 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.

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 however this was not formally recorded. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular 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 appraisal and 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 the practice had a relatively low number of elderly patients (79) compared with other practices in the local Clinical Commissioning Group (CCG)

The practice kept a register of those patients aged 75 years and over and had completed the required care plans. The practice offered a named GP for these patients in line with the new GP regulations. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice had commenced frailty assessments on elderly patients and these were used to inform the ongoing care plans for these patients.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

The practice had a higher than average number of patients with long standing health conditions (72.3% of its population). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. There was proactive intervention for patients with long term conditions. Patients had health reviews at regular intervals depending on their health needs and condition.

The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient with long term conditions effectively.

The Quality and Outcomes Framework (QOF) information indicated that patients with long term health conditions received care and treatment as expected.

Summary of findings

For those patients with the most complex needs GPs worked with relevant health care professionals to deliver a multidisciplinary package of care. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Staff demonstrated a good understanding of safeguarding requirements. They were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. They had undertaken a review of children at risk and liaised effectively with other agencies and health and social care professionals in minimising risk for those children. All new patients registering with the practice who were under five years of age were discussed formally with the health visitor and school nurse to ensure the patient and their immediate families could be supported in an appropriate manner.

The practice ran weekly baby clinics with the practice nurse and health care support worker supporting this. They offered a full range of childhood vaccinations.

Family planning and contraception services were available within the practice. Specific clinics were carried out weekly by the practice nurse. Nationally reported data demonstrated the practice had a high percentage of patients under 18 years of age (58.5% of the total practice population) and the local Clinical Commissioning Group area had a higher than average pregnancy rate for under 18's. Children and young people were treated in an age appropriate way and recognised as individuals.

Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and

Summary of findings

offered continuity of care. Early appointments were available and triage appointments were available both on the pre-booked system and on the day. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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 was aware of, and identified their vulnerable patients. This was highlighted within patient records. The practice discussed any concerning patients as a team, safeguarding policies and protocols were in place and staff were trained in safeguarding vulnerable adults and children. There were two safeguarding lead a GP and the practice nurse who had received appropriate training.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability and offered longer appointments and offered home visits if required.

Health promotion leaflets were available in languages which reflected the patient population and there was access to translation services for people whose first language was not English.

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 practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines. The practice regularly worked with multi-disciplinary teams and other mental health services in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

During our inspection, we spoke with five patients attending the practice. They told us that the GPs, the care they received and access to appointments were good. A member of the practice's patient participation group (PPG) told us that the practice listened to them and acted on their suggestions.

We received nine completed CQC comment card. They all praised the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 90% of respondents who described their overall experience of this surgery as good and 67% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care. 69% of respondents with a preferred GP said they usually got to see or speak to that GP.

One feedback comment card identified issues in trying to get through to the practice on the telephone at 8am but stated if you waited until 08.15 you could get through easier. 71% of respondents stating they found it easy to get through to this surgery by phone with 85% stating they found the reception staff helpful.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the first aider has updated training in the near future.
- Ensure clinical staff have access to appropriate uniforms for their roles.
- Ensure senior non clinical staff have access to mentorship to allow them effectively fulfil their roles.

Outstanding practice

- The practice had implemented frailty assessments for elderly patients.
- The practice had invested in their health care assistant (HCA) training and had given them the opportunity to enhance their role beyond usual boundaries. The HCA visited the elderly in their own home to assist in reducing the isolation of housebound patients and making sure their medicines are up to date.
- All new patients to the practice under the age of 5 years were discussed with the health visitor and school nurse to ascertain if they were known to services to allow the practice to support these patients fully.
- The practice had direct access to the electronic system used by their Out of Hours service which allowed them to add any changes to patient's conditions as they happened.

St Chads Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP, a specialist advisor who was a Practice Manager.

Background to St Chads Medical Practice

St Chads Medical Practice is located in Lime Green Oldham, within the Oldham Clinical Commissioning Group (CCG.) Services are provided under a personal medical service (PMS) contract with NHS England. There are 2800 registered patients. The practice population includes a high number (58.5%) of people under the age of 18, and a lower number (11.2%) of people over the age of 65, in comparison with the CCG average of 37.3% and 23.1% respectively.

There are comparatively high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The ethnicity mix of the practice population was predominantly white British with only 1% from other ethnic minority groups.

The practice opens from 8.00 am to 6.30 pm Monday to Friday and offers early appointments from 7.30am on Monday, Tuesday and Thursday. Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider (Go To Doc).

The practice has one GP partner and one salaried GP (female) working two sessions per week, one long standing locum (female) working two sessions per week. One practice nurses who was a nurse prescriber, one health care assistant, a practice manager, a business and finance manager, reception and administration staff. The practice is a training practice for medical students from the local NHS.

On line services include; booking appointments and repeat prescription requests.

The premises are multi-functional and are owned and maintained by an organisation who offers space to a number of health and social care facilities. The premises are compliant with Disability Discrimination Act guidelines. However the GP had identified areas in the practice that can pose problems to wheelchair users including the lack of electronic internal doors and he was currently in discussion with the building management company to address this.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

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.

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.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 17 March 2015.

We spoke with a range of staff including the GPs, a practice nurse, the health care assistant, reception staff, administration staff and the practice manager and business and finance manager on the day. We sought views from patients and representatives of the patient participation group and looked at comment cards and reviewed survey information.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 6 months. Significant events were a standing item on the weekly clinical practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff at the monthly staff meetings. Staff, including receptionists, administration and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw evidence to confirm that, as individuals and a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made.

Significant events, incidents and complaints were investigated and reflected on by the GP and practice manager and learning disseminated to the whole team where relevant.

The GP told us they completed incident reports and carried out significant event analysis routinely and as part of their on-going professional development. We looked at some recent significant events from 2015 which had been analysed, reported and discussed with relevant staff.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for. They also told us relevant alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed two staff as the leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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; for example children subject to child protection plans. All children joining the practice who

were under five years of age were discussed formally with the health visitor and school nurse to ensure they were aware the child had moved to the area and to allow them to deliver the appropriate care to the child.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice nurse, health care assistant usually acted as chaperone but were supported as required by two receptionists, who had been trained to be a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date. The fridges used for the storage of the vaccinations were pharmaceutical fridges.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Clinical audits had also been undertaken on the use of some medicines in response to alerts and we saw examples of these. Examples included the use of short acting bronchodilators in the management of asthma in patients under 19 years of age. This demonstrated the practice were within the recommended guidelines for this.

Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice nurse was appropriately trained to prescribe some medicines. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice worked closely with the pharmacist located on the same premises and regularly met with them to discuss medication prescribing trends. The pharmacist told us they were available to offer advice on medication prescribing as required to staff at the practice.

Medicines for use in medical emergencies such as anaphylaxis and hypoglycaemia were kept securely in the consulting rooms. We saw evidence that stock levels and expiry dates were checked and recorded on a regular basis. Staff knew where these were held and how to access them. There was oxygen kept by the practice for use in case of an emergency. This was checked regularly and checks recorded. The practice also had emergency medicine kits for anaphylaxis (where patients have adverse reactions to some medicines) . There was a system in place for monitoring and checking of medicines carried in the GP's bag. This was done by the practice nurse.

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. Comments recorded by patients on CQC comment cards referred to the practice as being clean hygienic and safe.

The practice had a lead for infection control (the health care assistant) who had undertaken training to enable them to provide advice on the practice infection control policy. The lead worked with the local authority's public health department to audit the practices' policies and procedures and implement an action to plan to improve the environment and staff working practices. The lead for infection control checked and audited the practice to ensure staff followed procedures. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and

aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were disposable and dated and changed in accordance with a planned schedule.

Procedures for the safe storage and disposal of needles and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Instruments used for minor operations carried out at the practice were single patient use and were stored, used and disposed of in line with manufacturer's guidelines.

The practice had a policy for the management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However this was maintained and carried out by the building management company.

Clinical nursing and health care staff at the practice did not wear uniforms when carrying out clinical activities. On discussion with the GP he acknowledged this would be addressed immediately in line with good infection control practice guidelines.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Contracts were in place for annual checks of portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Fire extinguishers and alarms were maintained and tested by the building management company.

Emergency drugs were stored in the consulting rooms. There was an oxygen cylinder and nebuliser equipment available and these were maintained and checked regularly. The practice did not have access to an automated defibrillator for use in emergency instead they used the 999 service for paramedic support.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) had been carried out for clinical staff. The business manager told us they were currently sourcing DBS checks for their non-clinical staff as none of these had been carried out on employment. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff which included detailed guidance on rehabilitation of offenders.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However due to natural wastage the practice had seen a considerable proportion of their staff retire in recent months and recruitment was still ongoing. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

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. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff which included both general workplace and clinical policies and procedures for staff follow.

Are services safe?

Arrangements to deal with emergencies and major incidents

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. Emergency medicines were available in the consulting room area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and suspected meningitis. 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.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by a contracted company

The practice had a first aider available however their training needed to be updated to ensure they could deal appropriately with any first aid emergency that may occur.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients spoken with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required.

New patient health checks were carried out by the health care assistant and cardiovascular and other regular health checks and screenings were on-going in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach.

Care plans had been put in place for just over 2% of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate.

The health care assistant carried out home visits where necessary to complete blood tests and blood pressure monitoring on patients who could not get to the surgery. As she knew the patients well she was able to alert the GP if she felt the patient was not their usual self and thereby initiate a visit by the GP. This process aimed to reduce the isolation felt by the housebound and to ensure their medication was up to date.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

The practice had recently started to complete frailty assessments of their elderly patients as part of their standard on-going assessment of need. This frailty assessment is defined as a multidimensional and diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to develop and carry out a coordinated and integrated plan for treatment, rehabilitation and support. The health care assistant had taken part in informal training and was due to attend the local Clinical Commissioning Group training in the near future to continue the assessment process.

Multi-disciplinary meetings were held regularly to discuss patients making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the review of patients taking Diclofenac (an anti-inflammatory medicine used to treat muscle and joint pain) following a safety alert. All patients who were taking the medicine were seen and the potential side effects were discussed with them and alternative medication was offered, all but two patients changed their medication to a different preparation.

We saw evaluations of medicines for patients under 19 years with asthma where treatment was changed if required so that the best outcomes could be achieved.

The practice reviewed patients under a locally enhanced service to minimise unplanned admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments such as MIND for patients with a mental health need.

The GPs undertook minor surgical procedures within the practice in line with their registration and NICE guidance. The health care assistant acted as chaperone and support to the GP during these procedures. Audits had been carried out by the GP and health care assistant on post-operative infection rates demonstrating one patient in the last two years had acquired an infection after minor surgery and this had been treated effectively at the time.

Regular meetings took place with multi-disciplinary attendance to share information and provide reflection and

Are services effective?

(for example, treatment is effective)

learning to the benefit of the patients. We saw evidence of collaborative working with school nurses, health visitors, district nurses and palliative care staff which resulted in positive outcomes for the patients concerned.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement .Discussion of audits, performance indicators and quality initiatives was evident in meeting minutes. Staff told us they were actively encouraged to contribute when discussing audits and performance indicators. They told us they received feedback through training days and at meetings.

Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives. The practice had access to the electronic patient records system used by their Out of Hours (OOH) provider so could update their patients care needs at the time of the change to ensure the OOH service was aware of the patients ongoing needs

Effective staffing

All staff at the practice were complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. The practice used Blue Stream on-line training**. Blue Stream** Academy provides eLearning/**online training** for GP practices. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff were multi-skilled and able to carry out the role of their colleagues as required to cover absence. Staff told us they had access to protected learning time for their training.

Most of the staff were long serving. There was an induction process for new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

Doctors were revalidated, nurse professional registrations were up to date and appraisals were carried out annually on all staff these were due at the time of the inspection.

The health care assistant had started at the practice as a receptionist and had accepted further roles and training and now work collaboratively with the GP and practice nurse in caring for the practice population.

All patients we spoke with were complimentary about the staff and we observed staff who were competent, comfortable and knowledgeable about the role they undertook.

There were enough staff to meet the demands of the practice.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services to maintain safe and effective care for their vulnerable patients. Regular communication and meetings with social services assisted this process.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates to the Out of Hour's electronic patient record system service in relation to patients receiving palliative care and if patients had signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

The practice had a close working relationship with Oldham Clinical Commissioning Group (CCG) and worked collaboratively on a number of both national and local initiatives. Plans for future initiatives were discussed with the team.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. One complaint we were shown had been in relation to a delayed appointment after referral to secondary care at the local NHS Trust, to address this the GP had referred this patient to another service where demand was not a great to assist in the timely management of the patients need.

Information Sharing

Information about significant events was shared openly and honestly at practice meetings. The GP attended CCG

Are services effective?

(for example, treatment is effective)

meetings and shared what they had learned in practice meetings. This kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

The practice used both electronic and fax systems to communicate with other providers. The Out of Hour's services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

There was a practice website with information for patients including signposting, services available and latest news. There were information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more private information.

Patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend meetings.

All staff completed mandatory training which included; information governance (IG) and confidentiality training. We saw the practice staff completed on line IG training which included; records management and the NHS Code of Practice, access to health records.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, (Principles that health and social care organisations should use when reviewing its use of client information) the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GP and the nurse we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us they had received training in regards to consent and Mental Capacity Act 2005 (MCA); The GP and clinical staff we spoke with were aware of the MCA and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

The 2014 national GP patient survey indicated74% of the 75 people at the practice who returned questionnaires said the last GP they saw or spoke to was good or very good at explaining tests and treatments which was below the local CCG averages. However 74% said the last GP they saw or spoke to was good or very good at treating them with care and concern and 96% had confidence and trust in the last nurse they saw or spoke to. Both these results were in line with local averages.

Staff informed us they had access to interpreter translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use.

Health Promotion & Prevention

All new patients were offered a consultation and health check with the practice health care assistant. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The waiting rooms were well organised with boards which were easy to read and had straight forward directions and advice on them.

The practice offered NHS Health Checks to all patients aged 40 to 74 years old.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to five patients in person and received feedback from nine via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the doctors.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation or treatment rooms. There were privacy curtains for use during physical and intimate examination and a chaperone service was offered. Clinical staff acted as chaperone for patients however if they were not available two reception staff had undergone training to assist in this role.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. There was a consulting room should patients like to speak in private with a member of staff.

Representatives from the Patient Participation Group (PPG) told us they believed the staff at the practice genuinely cared about their well-being. A retired patient told us they liked the efficiency of this practice. They said the practice sent them reminders by text message for appointments and the staff knew their name at the reception desk when they visited.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 74% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 89% of respondents said the last nurse they saw or spoke to was good at listening to them.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best. Patients told us they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information before giving consent.

Patients confirmed their consent was always sought and obtained before any examinations took place and this included consent to share records and written consent for minor surgery.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians and prominently displayed in the waiting areas. We noted that during our inspection patients readily picked up the practice information leaflets and browsed their contents.

The 2014 GP patient survey reported that 67% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 83% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Staff told us how patients were referred for secondary (hospital) care. When a referral was identified, the practice always tried to book an appointment with the involvement of the patient. They respected the patient's wishes wherever possible. They used the NHS choose and book system when choosing where the patient would like to have their care. Staff tracked referrals both manually and electronically to ensure patients had timely assessment of their continuing needs.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that because staff had been at the practice a long time, they understood people's personal circumstances and were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw written information available for carers in the waiting room to ensure they understood the various support mechanisms available to them.

Are services caring?

We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed. Staff told us families who had suffered bereavement were seen by the practice nurse and offered support via a drop in clinic.

Weekly practice clinical meetings with palliative care nurses, clinical staff and community health professionals were held to discuss patient treatment, co-ordinated care and support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patient's needs.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members.

Longer appointments were available for patients with long term conditions, learning disabilities or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

The GP we spoke was able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. The practice had very few housebound patients, therefore very few home visits were needed. The health care assistant visited housebound patients and reported any problems/issues that need bringing to the attention of the GP.

St Chads Medical Practice had a reception area, a patient waiting area, four consultation rooms and a treatment room. The treatment room was designated for carrying out minor surgical procedures. There were also facilities to support the administrative needs of the practice (including a reception office, practice manager's office and a meeting room). The entrance to the building was easily accessible to patients including those with a disability however the GP highlighted to the team, he was in communication with the building management team regarding the internal doors which were not automatic and caused some access problems for disabled patients or mothers with prams. Reception staff were always on hand to assist patients as required.

The practice had an active Patient Participation Group (PPG) and we saw that information about the PPG was displayed around the reception area. A section of the practice website provided information about the PPG and how it responded to patient needs and suggestions.

Tackling inequity and promoting equality

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. Annual reviews were scheduled for people who had differing needs, reception staff each took responsibility for ensuring patients had responded to their invitation request.

We also saw a small number of asylum seekers were registered at the practice and seen by clinicians so as to meet their needs. Their details were recorded on a separate register and translation facilities were available to all staff should they be required.

Access to the service

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday. Appointments were available 8.00 – 6.30 pm. Monday to Friday with extended hours on three early mornings Monday, Tuesday and Thursday starting at 07.30am. The practice explained they could not offer late evening appointments due to building regulations and the need to vacate the premises by 7pm. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances

Are services responsive to people's needs?

(for example, to feedback?)

We received no negative comments about being able to access the services at the practice other than one patient told us ringing the practice at 8am in the morning could sometimes be difficult but leaving it 10 minutes made the access easier.

We also looked the results of the 2014 GP survey 85% of respondents found the receptionists at the practice helpful, 94% of respondents said the last appointment they got was convenient, 78% were able to get an appointment to see or speak to someone the last time they tried and 90% of respondents described their overall experience of this surgery as good. These were both above the local CCG average for the area.

The GP triaged all requests for on the day appointments and then scheduled the patients who needed appointments into his diary. Patients told us they always got seen on the day if they needed it and it was usually within a few hours. One parent we spoke with told us her child had been unwell for a week and she had treated them with over the counter medicines. The parent had spoken to the GP today and he had offered an appointment within 20 minutes for her child. She was very complimentary about the service and explained this was the normal service she received not the exception. We saw that this system operated very effectively and patients spoke highly about access to appointments. Patients accessed appointments by telephone, in person or via the practice website. We saw that there were rotas and appointment planning in place to facilitate this.

The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where the GP used the electronic messaging system to prompt reception staff to create an appropriate appointment based on patient choice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both within the practice information book and leaflets as well as the practice website.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had needed to make a complaint but were aware of the process.

We looked at several complaints received in the last six months. In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints.

Patients told us on the day of inspection that the practice staff communicated with them well and said it was a two way conversation; they felt valued, listened to and staff genuinely cared about their well-being.

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

There was a well-established leadership structure with clear allocation of responsibilities amongst the GP's and the practice team. We saw evidence that showed the GP and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

We spoke to the GP about the vision and values of the practice, They were clear that communication between GPs, clinical staff, management, reception staff, patients and partner groups was essential. This was displayed in the regular meetings both formal and informal that took place. The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw that the practice had a documented statement of purpose which included their mission statement 'to improve the health and wellbeing of those we care for. Putting patient's needs at the heart of everything we do.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice.

Discussion with the GP and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits.

We saw that the risks were regularly discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

We were shown a clear leadership structure. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Most of the team had worked together for many years and there had been a very low turnover of staff. However in recent months a substantial proportion of long serving staff had retired resulting in recruitment of younger and less experienced staff. Staff told us that teamwork was very important and they felt as a team they were very effective in delivering high quality care.

We saw staff undertook annual appraisals. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. We discussed the potential for documented supervision meetings between appraisals as a method of evidencing staff support. The practice manager agreed that together with the open door policy and strong informal communications between staff and management, this would be a good idea.

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example sickness and absence, stress, bullying and harassment and equal opportunities, which were in place to support staff. Staff we spoke with knew where to find these policies if they required them for review.

The practice manager did not have overall responsibility for the running of the practice this was supported by the business manager who was based on a different site. We discussed with the GP the possibility of providing mentorship to the practice manager to allow her to take responsibility for all aspects of running of the practice, he felt this was appropriate and assured us he would address this as soon as possible.

Are services well-led?

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

Staff we spoke to were very complimentary about the GP's management style. We were told that support for learning, development and peer review was very good. Staff told us that the GP encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be added to the meetings. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the 2014 GP patient survey. This survey reflected medium to high levels of satisfaction with the care, treatment and services provided at the practice. The National GP survey showed particularly high levels of satisfaction from patients with 90% all respondents rating the service as good.

The practice had an active patient participation group (PPG) The PPG contained representatives from primarily the older population groups. We spoke to a member of the PPG who said that it worked effectively and was an excellent way of patients influencing the way the practice was run.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. They said that the excellent teamwork was instrumental in this.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

We found that the GP was committed to continuous learning, improvement and innovation. Clinical meetings took place each week and improvements through learning were discussed and shared where appropriate with the practice team.

The practice was a junior doctor training practice. We spoke with two junior doctors dung the inspection and even though this was their first day at the practice they were impressed with the way their training had been planned for them. We saw that the practice ensured that protected learning time was made available and regular mentoring and peer reviews took place.

The GP was supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. Clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments. The GP attended the Clinical Commissioning Group (CCG) protected time education initiative. This provided GP practice staff with protected time for learning and development.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved. Where appropriate significant events had been notified to the CCG in order that learning on a wider area base could be achieved.