Dr Bernard Newgrosh

Quality Report

Great Lever One
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Date of inspection visit: 15/12/2014
Date of publication: 31/03/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Great Lever One.

We undertook a planned, comprehensive inspection on 15 December 2014 and spoke with Dr Newgrosh, patients, four members of staff and the practice manager.

The practice required some improvements and is rated as requiring improvement overall.

Our key findings were as follows :-

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- 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
- Communication with patients, their families and carers, and access to the service and to the GP was excellent.
- The GP offered total open access on a first come first served basis.
- The practice created extra appointments to accommodate young families where possible and the GP spent a lot of time getting to know families in totality. He was aware of any issues within the family structure that might affect any of its members.
- The GP had been working single handed in the practice for the past twenty eight years without any management support. He had now employed a practice manager who was embedding policy and procedure and he was currently looking for a partner.

Importantly, the provider must:

- The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008, and necessary employment checks are in place for all staff.

There were areas of practice where the provider needed to make improvements. The provider should:

Summary of findings

- Fully embed policies and procedures such as infection control and ensure checks and risk assessments such as those for carrying medicines and prescriptions or relating to emergency equipment are rigorous enough to minimise error and ensure safety at all times.
- Ensure all staff receive training appropriate to their roles and identify and plan further training needs.
- Ensure there are systems in place to monitor quality and improvement and identify risk. Although patients were able to offer their opinion on the service whenever they wanted there were no formal surveys or questionnaires provided. The practice was not pro-active in asking patients for feedback.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Critical incidents and significant events were routinely recorded and reported. When things went wrong, reviews and investigations were sufficiently thorough and lessons learned were communicated widely enough to support improvement. However, staff recruitment was not sufficiently undertaken and reviewed. Some other policies and procedures such as infection control were not fully embedded and checks or risk assessments such as those for carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times.

Are services effective?

Good

The practice is rated as good for providing effective services. The quality and outcome framework (QoF) scores and dashboard indicators showed high overall scores for outcome measures such as long term conditions, carers, feedback by mental health patients and patient perception. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received some training appropriate to their roles but further training needs needed to be identified and planned. Multidisciplinary working was evidenced with positive impact on patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. The GP strongly believed their purpose was to care and look after patients and the practice went the extra mile to ensure that was achieved.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local

Summary of findings

Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported excellent access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a clear vision and strategy and staff were clear about their responsibilities in relation to it. There was a defined leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and regular governance meetings had taken place. However, some of the systems in place to monitor quality and improvement and identify risk were not sufficient. Although patients were able to offer their opinion on the service whenever they wanted there were no formal surveys or questionnaires provided. The practice was not pro-active in asking patients for feedback.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However, nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. Care plans had been introduced and implemented for 2% of the patients in the older age group to avoid unplanned admissions to hospital. Care was co-ordinated with other providers such as social services, Age UK, occupational therapists and other multi agency teams. We saw examples of how patients' wishes were respected at the end of their lives and how families were involved whilst still maintaining privacy and confidentiality for the patient.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for people with long term conditions. Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However, patients with chronic obstructive pulmonary disease (COPD), diabetes, mental health or other long term conditions were on appropriate registers. Alerts on patients with long term conditions were reviewed on a monthly basis and lists of patients with tasks or targets were appropriately followed up by the GP. The GP used quiet months to audit failed attenders on the chronic disease registers and there was a system in place to monitor recalls. Receptionists were given lists of patients to telephone and arrange follow up appointments when required. There were no specific clinics such as asthma, diabetes or cytology and patients were fitted into the appointment system when checks were required. Longer appointments and home visits were given if needed. For those people with the most complex needs the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for families, children and young people. Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to

emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However, systems were in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk. Immunisation rates were relatively high for all standard childhood immunisations and the GP carried out all immunisations personally. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses when required. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. Appointments could be made for families to be seen together or individually as requested. The GP created extra appointments to accommodate young families where possible. The GP also spent a lot of time getting to know families in totality and was aware of any issues within the family structure that might affect its members.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for people of working age (including those recently retired and students). Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However, patient needs had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered telephone consultations and blood test results by phone. The GP spent a lot of time getting to know the patients and their family dynamics. The GP was completely accessible to all patients offering one hundred percent open access. Patients sometimes had to wait more than an hour to be seen but everyone was seen when they needed to be on a daily basis if necessary. The GP made himself accessible up until 20.00hrs each evening if required.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for people whose circumstances may make them vulnerable. Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However, there was a register of patients with learning difficulties or who were homeless. The GP provided appointments which were appropriate to the consultations and specifically for people who were disadvantaged or vulnerable. Consultations included families and carers whilst maintaining privacy and confidentiality for the patient

Summary of findings

when necessary. The doctor regularly worked with multi-disciplinary teams in the case management of vulnerable people and patients were signposted when necessary to other organisations such as social services. The practice also provide assistance with appointments to secondary services. Staff said they would escalate any areas of concern and were knowledgeable about abuse and how it could and should be identified.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). Some checks and risk assessments such as those for recruitment, carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times. However there were high numbers of people experiencing poor mental health and the doctor worked closely with outside agencies such as social services.
Multi-disciplinary teams and housing agencies. Staff were patient and tolerant of behaviours presenting a calm approach. We saw an example where the doctor had responded to concerns of a carer which had led to a psychiatric admission and a positive outcome for the patient concerned. The doctor had also attended and stayed with a patient at hospital and followed up care with their family after the patient passed away.

Summary of findings

What people who use the service say

We spoke with eleven patients face to face, and a member of the Patient Participation Group (PPG). We reviewed comments from 37 CQC comments cards which had been completed. Of the 37 CQC comments cards completed there were no negative comments. Patients we spoke with said that staff were very helpful, caring and understanding and couldn't do enough to help. They felt that because they always saw the same GP (unless he was on holiday) it provided a really good relationship and that the GP knew them and their families exceptionally well. Everyone spoken with said the GP was the best they had had and they would not go anywhere else. The CQC comments cards reiterated those statements.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

Patients reported that their care and treatment was consistent because there was only one doctor who knew them very well and knew their medical history. They felt this was important to the continuity of their care. They reported that treatment was explained in a way they understood, they were not rushed through appointments and relatives and carers were included where necessary whilst still maintaining the patient's privacy and dignity.

Comments also reported that patients were referred on to other services and were well supported during transfer by the practice and its staff. Continuity was provided out of hours as much as possible as the GP continued home visits into the evening if he felt it necessary rather than handing over to the out of hours service.

Areas for improvement

Action the service MUST take to improve

The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008, and necessary employment checks are in place for all staff.

Action the service SHOULD take to improve

Some policies and procedures such as infection control were not fully embedded and checks or risk assessments such as those for carrying medicines and prescriptions or relating to emergency equipment were not rigorous enough to minimise error and ensure safety at all times.

Staff had received some training appropriate to their roles but further training needs needed to be identified and planned.

Some of the systems in place to monitor quality and improvement and identify risk were not sufficient. Although patients were able to offer their opinion on the service whenever they wanted there were no formal surveys or questionnaires provided. The practice was not pro-active in asking patients for feedback.

Dr Bernard Newgrosh

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP expert and an expert by experience. An expert by experience is someone that has used health and social care services.

Background to Dr Bernard Newgrosh

Great Lever One delivers primary care under a General Medical Services contract between themselves and NHS England. As part of the Bolton Clinical Commissioning Group (CCG) they are responsible for a population of 2020 within the surrounding area.

The practice offers access to one male GP and the services of a female practice nurse who is part time. Patients of the practice have access to community services within the health centre such as district nurses, health visitors, a physiotherapist, chiropodist and dietary clinics.

The practice opens at 08.30hrs and open access is available from 09.00hrs until 10.30hrs and from 16.30hrs until 18.30hrs every weekday. Patients are given an appointment number up until the end of the booking in time and the GP will see all patients who attend. Appointments are available three days a week from 19.00hrs until 19.30hrs for those people who are working or unable to attend the drop-in. The surgery is also open on a Saturday morning from 10.00hrs until 10.30hrs. No patients are turned away and the GP will continue to see patients if they turn up at the surgery or request an urgent appointment whilst he is still at the surgery. Patients spoken with confirmed this.

The GP has worked single handed for 31 years and knows his patients very well. A practice manager was employed two years ago for two days a week and has been further embedding training, appraisal, defined line management and policies and procedures.

The CQC intelligent monitoring placed the practice in band 4. 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.

The practice has opted out of providing out-of-hours services to their own patients

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

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 a range of information we held about the practice and asked other organisations to share what they knew. We asked Bolton Clinical Commissioning Group (CCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided.

We reviewed some policies and procedures and other information received from the practice prior to the inspection. Some of the information reviewed highlighted possible areas of risk across the five key question areas and we looked into these further during the inspection visit.

We carried out an announced visit on 15 December 2014. During our visit we spoke with three reception staff available on the day, the practice nurse, the practice manager and the GP. We interviewed eleven patients and reviewed comments from 37 CQC comments cards which had been completed. During the visit we observed interaction between staff and patients in the reception area and waiting room.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used information to identify risks and improve quality in relation to patient safety such as incidents and national patient safety alerts. They also routinely recorded and reported critical incidents and significant events and we saw evidence of these over the past two years. Incidents were logged and shared with the Clinical Commissioning Group (CCG) through an electronic portal. We saw that the practice manager worked closely with the CCG to discuss and receive advice regarding any incidents and events.

Staff we spoke to were aware of their responsibilities to raise concerns and how to report incidents. We saw examples of incidents reported by various members of staff who described the event, action taken at the time, discussions following the event and actions taken to prevent re-occurrence.

There was an accident book available in reception and staff knew how to log accidents. There had been no reported or recorded accidents over the previous two years.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events incidents and accidents. Records were kept of significant events that had occurred during the last twelve months and these were made available to us. Events were discussed at informal practice meetings on a Friday afternoon with all staff. These meetings were not minuted. However staff reported that the meeting took place and were able to describe events which had been discussed. They reported changes that were made to procedures to reduce the risk of the event occurring again in the future.

For example, a process for arranging transport for all patients was changed following an incident relating to one patient and a process for checking referrals on choose and book was implemented following an incident relating to one patient.

Reliable safety systems and processes including safeguarding

The GP was the safeguarding lead for the practice, understood their responsibilities and had undertaken some training with the Family Doctors' Association. However they were unable to evidence that they were trained to the expected level 3 in the safeguarding of children and adults.

The practice nurse understood what would constitute a safeguarding concern, was aware that the GP was the safeguarding lead and understood their responsibilities with regards to reporting any concerns. They had last received safeguarding training in 2012. Further safeguarding training in levels 1 to 3 had been arranged for the GP, the practice manager and the practice nurse and this was due to take place on 21 January 2015. Administration staff had received safeguarding awareness e-learning training in June 2013.

There was a local safeguarding children and vulnerable adults policy combined with Dr Newgrosh and Bolton Clinical Commissioning Group and a quick reference guide for staff which related specifically to procedures to be taken within the practice. This detailed actions to be taken if any concerns were noted and various contact numbers were listed. All staff were aware of the policy, what constituted abuse and what to do in the event of any safeguarding concern. We saw examples where concerns had been raised and action had been taken accordingly.

Patients spoken with said they were able to access a chaperone if they wished and there was a notice within the reception area informing patients what to do. Reception staff were sometimes asked to undertake chaperone duties and had been provided with awareness training. However not all staff were aware that they should stand inside the curtain and record their attendance on the patient record.

Medicines management

We checked the doctor's bag and found that appropriate medical peak flow meters (used for measuring breaths) and other equipment carried were all in date. A range of injections were routinely carried but a stock of injections was kept on the premises. Home visits were assessed and if it was deemed that injections were required they were taken from the practice. There were no known incidents or issues recorded to date to suggest that this system of managing medicines for home visits was ineffective or unsafe.

The GP was responsible for checking that the medicines carried in their bag were up to date and explained how they managed this. There was no written evidence of checks

being undertaken and whilst reviewing the medicines in the bag we found that one of the containers had a date which was not current. They were however still within their blister pack and the GP removed them immediately they were pointed out. The GP routinely carried Benzyl penicillin, adrenaline and hydrocortisone as per national guidance.

There was a process for ordering repeat prescriptions. No staff other than the GP himself had any rights to authorise or re-authorise prescriptions. If medicines were due for re-authorisation, then only one repeat was authorised. Following that the patient would be reviewed. No prescriptions were authorised over the telephone unless the patient was house-bound. The GP carried blank prescriptions when they went on home visits. Although these were kept locked when they were in the practice there was no system to note the numbers of the prescriptions and log them in and out when they were in use.

The GP did not engage with the medicines management team as they did not find it useful and medicines management was not an agenda item on any of the staff meeting minutes. However, three local pharmacies kept the GP up to date with pricing and economy issues and the availability of alternative preparations to minimise cost.

Cleanliness and infection control

We observed the premises to be clean and tidy and saw that facilities such as hand gels, paper towels and hand washing instructions to encourage hygiene were displayed in patients' toilets and in the treatment rooms. Pedal bins were available in treatment rooms but the toilets had open waste paper bins for the disposal of paper towels. We noticed on a visit to one of the toilets that the bin was overflowing. However we were able to speak to one of the cleaners who were employed by the owners of the building. We saw that there was a cleaning schedule which was adhered to and that the bins were emptied at least twice a day. We saw on a later visit to that toilet that the bin was cleared.

The practice did not use single-use equipment although disposable specula were available. Reusable equipment such as specula for smear testing, ear irrigation equipment and spirometers (used to diagnose asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing) were sanitised and decontaminated appropriately. We saw cleaning schedules which were maintained and kept up to date by the practice nurse. We looked at the decontamination unit which was the sole responsibility of the GP. We were shown the decontamination process and saw that instruments were kept in sealed bags once cleaned, which were appropriately dated. We saw print outs which satisfied us that the unit was monitored to ensure its validity and that it remained in good working order. Protective equipment including disposable gloves, aprons and coverings were available to clinical staff.

The practice policy stated that an annual infection control audit should be completed. There was no CCG audit of infection control carried out but we saw a self-assessment dated 2013/2014. The assessment highlighted areas for attention and these were being reviewed. However, the assessment did not identify areas such as curtains around treatment beds which were not disposable. The curtains we looked at were not dirty but it appeared they had been up since 2005 and there was no cleaning schedule to advise when they were cleaned or due to be cleaned and who was responsible for doing this. The practice manager undertook an annual room audit but we did not see evidence to support this. Although the GP was stated in the policy as infection control lead there were no meetings attended and no updates passed on to staff as required. The GP and practice nurse were each responsible for cleaning their own equipment and maintaining their own checks that these were done appropriately. The practice policy stated that all staff should be trained in infection control. We did not see evidence that this was the case.

Equipment

There were contracts in place for annual checks of fire extinguishers, lights, boilers and plumbing which were undertaken by the Estates Department of the NHS services who owned the building. Service level agreements were in place to ensure that issues were dealt with in a timely manner and the practice manager reported that there had never been any delays that had adversely affected the service. On the day of the inspection we saw evidence of these agreements in action when the heating system failed and the maintenance providers were requested to carry out repairs. However we saw that one of the disabled toilets was out of order and staff and patients reported that this had been out of order for some time. Another disabled toilet was available for use.

Requires improvement

Are services safe?

We saw that the decontamination equipment was maintained regularly by the manufacturers and was in good working order. Some portable appliances had not been recently tested to ensure they were safe and there was no monitoring system in place to ensure these were kept up to date. The practice used Gold Standard blood pressure measuring instruments with a lifetime guarantee which did not require calibration. We reviewed the documentation for this equipment which provided confirmation. Blood pressure was measured using wrap around cuffs and there were several different cuffs dependent on the size of the patient to ensure accurate diagnostic results.

Emergency drugs were stored in the locked cupboard and any vaccines were appropriately stored in a fridge specific for that purpose. Fridge temperatures were checked twice daily and we saw logs to ensure that they were within acceptable limits. We saw that there was an appropriate cold chain. The cold chain maintains optimal conditions during the transport, storage and handling of vaccines and ensures that their temperature is kept at the correct level.

We asked if appropriate staff were aware of what should be done in the event of fridge or cold store failure and we were told that this would be reported.

Staffing and recruitment

Most of the staff had been at the practice in excess of five years, one over 20 years, but there had been an addition to the team in October 2014. The practice had a recruitment policy in place but the policy was not dated and was not sufficient to support requirements relating to workers.

There was no stipulation in the policy to request disclosure and barring service (DBS) checks before a person was offered a position. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, specifically children.

There was no stipulation in the policy to request training certificates which ensured an applicant had the appropriate qualifications, skills and experience required for the role or identification which ensured they were who they stated and were eligible to work in the UK. The policy did not outline that verbal offers of employment were subject to the receipt of satisfactory references.

We reviewed four staff files including the person who had most recently been employed. There was no evidence of references, Disclosure and Barring Service (DBS) checks, risk assessments to support why DBS had not been obtained, job descriptions, work history or other supporting information.

Reception staff were multi-skilled which enabled them to cover each other's roles and they reported that they had good relationships and cover was always arranged between them. The practice never used locum clinical staff and when medical cover was required, for instance when the GP went on leave, a GP from another known practice was used.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included informal walk arounds of the building by the practice manager to ensure that any hazards were identified. Administration staff we spoke to were also aware to be on the lookout for hazards that may be harmful to people such as unidentified bags and packages or dangerous cleaning chemicals. However, there were no formal checks undertaken and no evidence to support the checks that were carried out.

Staff told us about arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and the practice manager was 'operational' and could fill in if required. There was one nurse at the practice and there no cover available for planned or unplanned absence. We were told that in the event of planned leave the nurse appointments were re-scheduled. However during periods of unplanned absences the nurse clinics would have to be cancelled (with appointments rearranged) and the GP would pick up any work that was necessary. The nurse told us that they would avoid taking leave at busy times and that the GP was very supportive when help was required.

There was a business continuity plan which contained a business risk assessment and plan of action. The GP and practice manager were responsible for any updates. However other staff spoken with were not aware of any business continuity and felt they would be told what to do in the event of any failures. The building owners had overall responsibility for maintenance and health and safety of the whole premises and there was a caretaker available to monitor the security of the premises.

Requires improvement

Are services safe?

The GP had participated in a holiday cover arrangement with other single handed GPs to cover each other during periods of planned and unplanned leave and this was working well and maintaining continuity of care for patients. Administration staff were able to carry out each other's roles and covered for each other at times of sickness or annual leave. They worked well as a team and supported each other and the GP and nurse very well.

Arrangements to deal with emergencies and major incidents

We saw that all staff had received basic life support training in March 2014 and clinical staff had advice to follow in the event of anaphylaxis. The newest member of staff employed in October 2014 had not yet completed basic life support training. Staff spoken with said they were trained and would know what to do in the event of an emergency. The GP and the nurse both knew how to administer CPR and there was a nebuliser and pulse-oximeter available at the practice. An emergency resuscitation box was available in one of the GP consulting rooms. However there was no oxygen or defibrillator within the building and no risk assessment had been provided to evidence the needs of patients in an emergency. Oxygen may be required to deal with dealing with certain medical emergencies such as acute exacerbation of asthma and other causes of hypoxemia.

All staff had been trained to deal with conflict resolution and there were panic buttons on all computers. The nurse also carried her own panic button and there was one in each treatment room as well as in the disabled toilets.

We were told that the community receptionist was the fire marshal and responsible lead for fire checks and evacuations of the building but she was not a member of the practice staff. An annual fire risk assessment was carried out by the practice manager and we saw the last assessment dated 5 November 2013. The fire alarms were tested each Tuesday by the community services.

Staff at the practice reported that there had been fire evacuation drills and said they knew where to congregate in the event of a fire. However there was no practice specific fire procedure and no one with specific responsibility within the practice to carry out tasks in the event of a fire. Staff reported that they would all help to evacuate the surgery if necessary but did not know if the community receptionist was responsible for co-ordinating evacuation, calling the fire brigade or ensuring that everyone had left the building. Although fire training had been undertaken by the practice manager in their previous role, training for other staff was not recorded as having been undertaken in the last three years.

Good

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 their treatment. New patient health checks were carried out and other regular health checks and screenings were ongoing in line with national expectations. Care plans had been introduced and implemented for two per cent of the patients in the older age group to avoid unplanned admissions to hospital. Care was co-ordinated with other providers such as social services, Age UK, occupational therapists and other multi agency teams.

Patients with chronic obstructive pulmonary disease (COPD), diabetes, mental health or other long term conditions were on appropriate registers. Alerts on all patients with long term conditions and other modalities were reviewed on a monthly basis and lists of patients with tasks or targets were given to an appropriate member of staff to follow up. There was a system in place to monitor recall and receptionists were given lists of patients to telephone and arrange follow up appointments. Staff had clinical guidelines available to them. They were able to access these during consultation or between surgery sessions as necessary to ensure that the most appropriate treatment was being offered.

Patients were referred to secondary services when appropriate and this was decided at consultation or over a period of time following tests. Referrals to secondary services were made through the Choose and Book system which enabled patient choice. The practice participated in the Clinical Commissioning Group's (CCG's) 'Triple Aim' and 'Best Care' projects to enhance patient care. Triple Aim seeks to improve patient experience of care by improving the health of a complete population and reducing overall cost. Best Care provides an integrated service which centres around the patient's needs and aims to keep them well and independent within their own homes.

Management, monitoring and improving outcomes for people

The GP completed several regular clinical audits. In particular an annual audit took place to identify patients who may have dropped out from follow up and/or treatment. The numbers were usually very low (two or three) but identification of those patients ensured that all patients received adequate health care. Every effort was made to contact the patients and draw them back into follow up. Other audits included checks by the nurse on inadequate smears, non-attendance of flu vaccinations and childhood immunisation, a rag system to identify over 75s at risk and an audit of carers and those cared for.

The GP reviewed patients to minimise admissions to hospital, specifically in older people, and care plans were in place. If gaps in service provision were found, action was taken so as to improve the patient experience by signposting to other agencies and co-ordinating care through regular communication. The GP was able to utilise district nurses and other health professionals located in the building and often 'walked along the corridor' for advice and support. This meant that patients could receive quick responses to queries which might otherwise delay their treatment.

There was support for young mothers who could be seen with their families or individually if preferred. The GP liaised with health visitors and school nurses and created extra surgeries to accommodate young families where possible. The nurse was highly trained in the care of asthma and chronic obstructive pulmonary disease (COPD) and had identified patients who had been erroneously diagnosed in secondary care with this disease. This has enabled treatment to be changed accordingly.

Effective staffing

All the staff apart from one had been with the practice in excess of three years, some for over 20 years. There was an induction process for any new staff to be completed within the first month which covered basic training such as basic life support, fire, and reception training. We found them to be competent in the role they were carrying out. However their induction was not complete as per the practice induction policy. We looked at the staff file of this person most recently employed and found that the required documentation relating to their employment had not been obtained.

Two reception staff spoken with said they felt confident in their roles and were adequately trained. We saw that staff had completed a course on 28 March 2013 around information governance, equality and diversity, safeguarding, conflict resolution, fire training, health and

Good

Are services effective?

(for example, treatment is effective)

safety, effective community, customer care and CQC requirements. Administration and reception staff had undergone an annual appraisal and felt supported in their employment.

We saw that the nurse's professional management was kept up to date. They had not yet been appraised this year and we were not shown evidence of previous appraisals. The GP was revalidated in August 2013 and last appraised in August 2014. The practice manager was appraised by another manager in another practice. Some formal training had been requested and learning time was available.

Working with colleagues and other services

The practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services who shared the building and professionals from other disciplines to ensure all round care for patients.

The GP was a convenor of the Bolton Medical Holiday and Sickness Scheme which was a co-operative of small practices around the borough that offered holiday and sickness cover and support for the staff of the practices during leave or absence of its GP. This ensured continuity of care for patients.

Health visitors, district nurses and MacMillan nurses had open access to the GP who would speak to them at any time to deal with any concerns they had about patient care. There were also informal monthly meetings with other health care professionals held on Friday mornings once a month. The GP had similar open access relationships with local pharmacists. The practice regularly informed the Clinical Commissioning Group (CCG) of clinical incidents which affected the delivery of care.

The GP had access to the local NHS Trust integrated record service and this enabled review and management of blood results, discharge letters and other notifications. An alert system notified of results in the "inbox" and these were reviewed and dealt with as required. If action was identified, such as low warfarin results the GP would deal with the matter himself. Hospital discharge letters were also reviewed in this way and out of hours information was also dealt with in this way.

Information sharing

We saw minutes from staff meetings in August, September and October 2014. These were attended by the GP, the practice nurse and the other practice staff. The meetings were structured and followed a specific agenda which covered clinical systems, referral delays, treatment options and significant events. We saw that the GP met regularly with the practice nurse and the nurse herself reported that the GP was very supportive and accessible during patient consultation if required.

We saw that information was shared appropriately when patients moved between services and were referred on to other teams in a timely manner. We also saw that the GP regularly signposted patients to other services and followed up their treatment at the next consultation. Information about their condition was either given to the patient or sent to the follow up service in a letter.

The GP typed all referral letters during surgery consultations in the presence of the patient. Hospital letters and discharge documents were all reviewed by the personally by the GP. We saw examples where information was shared with secondary care consultants and palliative care nurses and were told of examples where errors in treatment had been identified by the GP and corrected through discussions with secondary care. Out of Hours information was received through the local Trust's shared information system.

Consent to care and treatment

Clinical staff spoken with understood requirements around consent and decision making for people who attended the practice. The GP described situations where best interests or mental capacity assessment might be appropriate and was aware of what should be done in any given situation.

We saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. Consent was discussed during consultation. Patient specific directives were used to obtain consent before any invasive treatment, such as flu injections or child immunisations. We saw a practice policy in place which explained all areas of consent such as expressed and implied consent and Gillick competency to assess young people's ability to understand or consent to treatment. There was also mention of Mental Capacity Act guidance for people suffering mental capacity issues.

Health Promotion & Prevention

All new patients were offered a consultation and health check with the GP. This included discussions about their

Good

Are services effective?

(for example, treatment is effective)

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 GP undertook first assessment care plans with all new patients. The staff were pro-active in producing lists of patients needing blood tests, care review or medication review and appointments were made to see clinicians when care or treatment was required. The GP was very knowledgeable about all his patients and personally monitored when they required review.

The care provided by the practice was in line with clinical evidence and the care was personalised, holistic and aimed to enhance recovery and well-being. The practice was in an area of high social deprivation with high unemployment and the doctor supported patients to improve or enhance their physical health. We were given several examples where family members or carers were involved (with the patient's choice) in their care and treatment; where the GP encouraged healthy living; where disadvantaged patients were helped to make secondary care appointments and where the GP liaised at length with other health and social care professionals to maximise treatment provided to patients right up until the end of their lives.

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.

Flu injections were provided by the nurse and GP and clinics were held to check blood pressures and advice on other health matters such as smoking, weight loss and drug or alcohol issues.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt more than just well cared for and that staff were very considerate, friendly and genuinely concerned and attentive to their needs. The GP did not just show empathy and respect for the patients, but genuine concern and a genuine desire to make them well. On the day of inspection we saw that the patients and the GP interacted with each other in a friendly, familiar way and we were told by patients that they did not mind waiting to see be seen because they knew the GP understood them and their conditions.

We were told that privacy was maintained during consultations, curtains were used to hide modesty and blinds were closed. Conversations could not be heard through closed doors. Patients spoke very highly of the practice, the reception staff, the nurse and the GP.

Reception staff were respectful and patient and worked in a calm and well-ordered manner. Patients were able to speak with reception or management in private if they wished to do so. There was a genuine and friendly connection between the reception staff and patients of all ages. Comments cards showed a high degree of satisfaction with the service provided and the attitude towards them by the staff who delivered it. We looked at the results of the 2014 GP patient survey which is an independent survey run by Ipsos MORI on behalf of NHS England. 99% of respondents said that reception staff were helpful and 94% thought the GP was good at listening to them.

The patients had been with the practice for many years and some told us that all their families, children and grandchildren, used the same practice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of inspection told us that health issues were discussed with them and they felt involved in decisions about their care and treatment. They said they felt listened to and supported by the GP and the nurse and were given sufficient time during consultations to make informed decisions. Patient feedback on the comment cards we received was completely positive and aligned with these views.

The GP undertook care planning for older patients as part of locally enhanced service and all had been completed.

The staff we spoke to were effective in communication and all knew how to access and use Language Line if required. Language Line is a worldwide telephone interpretation service. We saw that patients' information was treated with confidentiality and that information was shared appropriately when necessary using the correct data sharing methods. The GP had also learned ways to communicate with patients whose first language was not English so that they were comfortable to attend consultation without their partners or interpreters if required. An example of this was provided to us.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that the GP, and reception and management staff were able to provide emotional support when required. Reception staff described incidences when they had gone over and above their required obligations to ensure that people were safe and cared for. The GP also provided examples where he had provided his personal telephone number and undertaken home visits out of hours when he was not on call. This was to ensure continuity of care for patients who were either at the end of their life, or had been particularly ill and may require the help of a GP at any time.

Thirty-seven comments cards were completed and all the comments were positive. Some patients commented that they waited a long time to see the GP but it was worth the wait because they got the help they needed.

We were told of examples where the doctor and the practice team had supported people in times of bereavement and had attended the homes of those who had passed away. There were many cards of thanks displayed in the reception area from satisfied patients. We saw from these cards that patients were supported through all sorts of emotional circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example patients who were housebound were identified and visited at home when required. The practice tried to call people on the telephone rather than writing letters and this included reminders about appointments, flu jab campaigns and blood tests. Patients who repeatedly did not attend, specifically expectant mothers and children, were monitored and contacted to find out the reasons.

The practice had reviewed the needs of their increasing local population and identified that a partner was required. They were in the process of looking for a doctor to fill the post.

Staff turnover was limited and this enabled good continuity of care. The GP provided longer appointments for people who needed them and undertook home visits every day. Patients with families reported that they were seen whenever they needed to be and looked forward to being able to see the same GP at every visit.

Tackling inequity and promoting equality

The premises were shared with one other practice and community services. There were a limited number of chairs for the amount of people attending the two surgeries. We noticed that some people had to stand whilst waiting for their appointment. There were two reception areas with each practice's area clearly labelled. People we spoke with were happy with the waiting area and the seating provided which was all of one height and size. There was no variation for diversity such as old age or physical disability.

An audio loop was not available for patients who were hard of hearing but staff were knowledgeable about the different needs of the patients who attended and they altered working practice to accommodate them. For example we were told of one patient who was deaf and they used pen and paper to communicate with them. There was disabled toilet access and baby changing facilities were available.

We saw a large diversity in the patient population and noted that information was available in several different languages. The GP had made efforts to learn some of the words from some of the different languages and helped people to communicate so that they could attend appointments without their partners or interpreters if they wished. Reception staff were also knowledgeable about language issues and described how they would access an interpreter or use language line if necessary. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

The practice was open from 8.30am and open access was available from 9am until 10.30 and from 4.30pm until 6.30pm every weekday. Patients were given an appointment number up until the end of the booking in time and the GP saw all patients who attended. Appointments were available three days a week from 7pm until 7.30pm for those people who were working or unable to attend the drop-in. The surgery was also open on a Saturday morning from 10am until 10.30am. We were told that no patients were turned away and the GP would continue to see patients if they turned up at the surgery whilst he was there or requested an urgent appointment. Patients spoken with confirmed this. We also saw an example of this as we were there during an afternoon when the surgery was closed. A parent attended with their child (as the surgery door had been left open by another patient) and although surgery was closed, the GP saw the child because the parent had come to the window.

Results from the 2014 GP data survey showed that 100% were able to get an appointment to see or speak to someone the last time they tried. 95% described their experience of making an appointment was good and 99% said the last appointment they received was convenient.

Patients were very satisfied with the appointments system and did not mind the fact that they had to sit and wait. Disabled access at the front of the surgery was good with smooth well-kept surfaces and ramps. Doors were wide enough for wheelchairs, there was plenty of room in the waiting room and corridors and disabled parking spaces were available.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. There was a designated person to handle complaints within the practice.

Patients we spoke to reported that they would address the practice manager with any complaints but there was information to help patients understand the complaints system if they requested it. There was an up to date practice leaflet in reception which explained the complaints and information was also available on the practice website.

We looked at complaints received and saw that these were handled appropriately and, according to the reports the matters were resolved. We saw that lessons were learned from feedback and changes were made to working practice where appropriate so that any errors were not repeated.

Are services well-led?

Requires improvement

(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. All staff spoken with upheld these values and were encouraged to do the best for the patient. We spoke with six members of staff and all knew and understood the vision and values and their responsibilities in relation thereto. Quality and care were central to the GP's beliefs. The GP had thought about succession planning and the vision and strategy for the future was to have a partner.

Governance arrangements

A number of policies and procedures had been implemented by the practice manager and staff knew where to access these policies when required. Although policies had been introduced in order to comply with requirements there was no evidence that they had been fully embedded into the workings of the practice and some that we looked at required review to bring them in line with requirements. The recruitment policy in particular required a complete review and recruitment procedures needed to be as specified in the recruitment policy.

The practice manager attended Clinical Commissioning Group (CCG) meetings to identify needs within the community and fed back to staff through practice meetings. The GP worked with local safeguarding organisations to make sure they were aware of the requirements within their patient population. If necessary they would pass on information to the practice nurse through informal discussions. Staff meetings were held regularly on a weekly basis, but not all meetings were minuted which meant the practice were unable to provide written evidence of what was discussed. However, the staff we spoke with said that any practice issues were discussed and that they recorded any actions for completion in their own books. We saw the books where they recorded this information.

Leadership, openness and transparency

All staff were clear about the lines of management and areas of lead responsibility such as infection control and safeguarding. Staff said that the GP was the lead for everything and said they would report any issues about anything to them or the practice manager. We were told that both were very approachable and there was an open, honest and friendly culture within the team who worked well together and socialised together at holiday time such as Christmas. As the practice was so small we also established that in the event of concern or worry about the GP or the manager they would speak to another colleague and escalate the matter from there.

Staff understood their roles and were clear about the boundaries of their abilities. During discussions they said they felt supported in their roles. We discussed supervisions, appraisals and training opportunities and staff felt they were appropriately supported and trained for the roles they undertook. However the practice nurse, who was previously trained in infection control, was not utilised in this role and did not take the lead for this subject.

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

The practice made changes in response to suggestions if they were received, for example the car park was renewed and disabled parking spaces increased. However, there were issues with the broken toilets which had not been resolved. This was in part due to the fact that the building was the responsibility of the Estates Department and not solely that of the practice.

The practice did not pro-actively seek feedback through patient questionnaires or surveys, which they did not believe in. They had tried to form a patient participation group but it was not pro-active. There were notices on the notice board but a proper group had not been formed.

Feedback was available from the national patient survey but the practice did not pro-actively review the results and make changes based on them. We received thirty seven CQC comments cards and all the comments were positive.

Management lead through learning and improvement

There was an understanding by the management team of a need to ensure that staff had access to learning and improvement opportunities. This was monitored and reviewed effectively.

We were able to establish that the nurse and GP kept their continuing personal development up to date and we saw that the practice nurse was up to date with their professional development. The practice nurse reported that the GP was very open and supportive and that they had time to reflect on their practice so that improvements

Are services well-led?

Requires improvement

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

could be made. They also had individual objectives and team objectives that aimed to improve the quality of care for patients. For example they were continually reviewing the way long term conditions were managed to make sure the patients received holistic care and treatment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not have effective recruitment procedures in place, as specified in Schedule 3 of the Health and Social Care Act, to ensure that persons employed by the practice were suitable.**