Albion Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Albion Medical Practice on 7th April 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses although we were alerted to a significant event that had not been formally reported.
- Following our last inspection, when a compliance action had been issued about the management of medicines, the practice manager had shared our findings with the other practices in the Clinical Commissioning Group (CCG) in an effort to improve cold chain management throughout the entire CCG.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice had adopted the Gold Standards Framework to deliver care to their patients. GSF is a way of working adopted by GP practices which involves them working as a team with other professionals in hospitals, hospices and specialist teams in order to provide the highest standard of care possible for patients and their families
- 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.

Summary of findings

- Information about services and how to complain was available and easy to understand.
- Patients mostly said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw an area of outstanding practice:

The practice had recently employed a team of staff to provide an "Over 75s" project and work specifically with the 797 older patients at the practice and maximise the quality of care provided to this group. A GP, community liaison nurse and the services of a pharmacy technician had been secured. The team were working with this age group to provide advice and promotion of good health, a point of contact for signposting, post-hospital discharge visits, advice with finances and reviews of medication. We saw three examples where this team had a positive impact on patients and promoted good outcomes.

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

The provider should :

- Ensure that all members of staff are encouraged to report and record all significant events that happen within the practice.
- Ensure that all staff files contain the required documentation with regard to employment, such as satisfactory evidence of conduct in previous employment.
- Ensure that non-disposable curtains in consulting and treatment rooms are laundered at least six monthly and that dates are documented and kept for future reference.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and mostly fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However we were alerted to a significant event which had not been formally reported or recorded as we would have expected. We saw that lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. There was evidence of appraisals for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular 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 and involved. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice had recently employed a team of staff to provide an "Over 75s" project and work specifically with the 797 older patients at the practice and maximise the quality of care provided to this group. A GP, community liaison nurse and the services of a pharmacy technician have been secured. The team were working with this age group to provide advice and promotion of good health, a point of contact for signposting, post-hospital discharge visits, advice with finances and reviews of medication. We saw three examples where this team had had an impact on patients and promoted good outcomes. These included a medication review which improved a patient's whole quality of life and an opportunistic "message in a bottle" plan for an elderly patient worried about their pet if they had to go into hospital. The practice felt that these were personal touches that the staff were able to provide because of the extra time they were able to spend with the patients.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services 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 held a register of patients living in vulnerable circumstances such as those living alone or those with a learning disability. It had carried out annual health offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with 11 patients and reviewed comments from three Care Quality Commission (CQC) comments cards which had been completed. Most of the comments were positive. Patients spoke highly of all the staff and in particular praised the receptionists for their kindness and patience. Comments included praise for the GPs who were said to be thoughtful, thorough and good at putting patients at ease. Most patients found ordering prescriptions easy, with no issues. They told us they received regular health screenings and that medical histories were asked for if they didn't see their named GP.

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

We reviewed the results from the latest GP Survey where 112 responses out of 294 questionnaires issued were received. This was a 38% completion rate. The practice scored higher than the local CCG average in the following three aspects :

98% of respondents had confidence and trust in the last GP they saw or spoke to – Local (CCG) average: 95%.

81% said the last GP they saw or spoke to was good at involving them in decisions about their care – Local (CCG) average: 80%

87% said the last GP they saw or spoke to was good at explaining tests and treatments – Local (CCG) average – 85%. 91% said the same of the nurses at the practices.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all members of staff are encouraged to report and record all significant events that happen within the practice.
- Ensure that all staff files contain the required documentation with regard to employment, such as satisfactory evidence of conduct in previous employment.
- Ensure that non-disposable curtains in consulting and treatment rooms are laundered at least six monthly and that dates are documented and kept for future reference.

Outstanding practice

The practice had recently employed a team of staff to provide an "Over 75s" project and work specifically with the 797 older patients at the practice and maximise the quality of care provided to this group. A GP, community liaison nurse and the services of a pharmacy technician had been secured. The team were working with this age group to provide advice and promotion of good health, a point of contact for signposting, post-hospital discharge visits, advice with finances and reviews of medication. We saw three examples where this team had had an impact on patients and promoted good outcomes.

Albion Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a nurse specialist adviser as well as an expert by experience. An expert by experience is someone who has used health and social care.

Background to Albion Medical Practice

Albion Medical Practice is located near Ashton-Under-Lyne town centre and has a patient population of 9750 people who live in the local area. The population is not particularly diverse and most patients are white British. The building has three levels, the lower of which is used by the nursing staff. Wheelchair access is available to the nurse consulting rooms through a back lower level entrance. The top level of the practice is utilised by the administration team and the practice manager.

The practice opens Monday to Friday between 8am and 6pm. On Wednesdays they are open later until 7.30pm and on Thursday mornings earlier at 7am. On a Thursday afternoon the practice is closed for training. Telephones are answered until 6.30pm every day and until 7.30pm on a Wednesday. Clinics include minor surgery, medical examinations, family planning, child health services, substance and alcohol misuse, young people and mental health services.

There is a large compliment of staff with five GP partners, two part time salaried GPs and a GP trainee. The nursing staff, who are all part time, consist of three practice nurses, an assistant practitioner and a phlebotomist. There is also a vacancy for an advanced nurse practitioner.

A salaried GP, along with a pharmacy technician and a nurse have been employed to work on the "over 75s project" which is a government initiative implemented by the practice and commissioned by Tameside and Glossop Clinical Commissioning Group (CCG). The CCG has a significantly higher proportion of older adults affected by income deprivation with a negative effect on their health and wellbeing. One of the priorities of this project is to increase communication with patients over the age of 85, living alone in their own homes with irregular contact to the GP practice and ensure they are receiving health, social care and benefits they are entitled to.

Six administrators, a practice manager and six part time receptionists with a reception manager all managed the day to day running of the practice.

Health visitors and district nurses are attached to the practice and contactable at a neighbouring clinic. A group of midwives attended the practice on a rotational basis and patients can make appointments through the practice reception. An urgent surgery is available between Monday and Friday and patients also have access to Ashton Walk-in Centre and the Out of Hours Service (Go-to-Doc) during evenings and weekends.

Why we carried out this inspection

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

Detailed findings

We carried out a comprehensive inspection of the service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We also reviewed a compliance action in relation to the management of medicines following an inspection of the practice on 14th May 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7th April 2015. During our visit we spoke with three GP partners, the practice manager and nurses, reception and administration staff. We spoke with 11 patients and reviewed comments from three CQC comments cards received. Following the visit we spoke to two nursing home managers and members of the patient participation group (PPG).

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety such as accidents and incidents and national patient safety alerts. We saw that accidents were recorded in the staff accident book. The practice logged comments and complaints from patients and there was a system in place, understood by all staff, to record and report any significant events that happened. Staff we spoke with said they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. However, during conversations with one member of staff we were told of an event which was significant. The member of staff had discussed the event with the other practice staff but it had not been formally reported as a significant event and was not formally documented outlining any learning that had been identified.

We reviewed safety records completed over the previous few years and incident reports and minutes of meetings where these had been discussed. The contents in the documentation showed that the practice had identified learning and we saw that incidents were managed consistently over time evidencing a safe track record over the long term.

Learning and improvement from safety incidents

There were records of six significant events over the previous twelve months which showed details of the incidents, actions taken and lessons learned. Agendas for meetings had significant events as a standing item. Information and any changes to practice were shared with relevant members of staff. Staff, including receptionists, administrators and nursing staff told us they knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

However, we were made aware of a significant event which had not been formally recorded. It related to the electronic prescribing system which had failed over a period of two days, negatively impacting patients expecting prescriptions for collection at their chosen pharmacy. The issue had been the fault of the system and not the practice, and although it had been resolved there was no evidence that it had been formally discussed with learning of what to do if it happened again in the future.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result of a near miss in connection with a prescription and learning for clinical staff to be extra vigilant by checking repeat prescriptions before altering doses.

National patient safety alerts came directly to the practice manager who passed them on to the appropriate members of staff. Depending on the nature of the alert it would be discussed with relevant members of clinical or nursing staff and brought to the attention of GPs at partner meetings if necessary. We saw an example of an alert which highlighted contra-indications of prescriptions in patients with cardiac conditions. This had been discussed and clinicians had been advised to make changes in prescribing if required.

Reliable safety systems and processes including safeguarding

There were systems in place to review risks to vulnerable children, young people and adults. All staff had received level one and two safeguarding training in June 2013 and this had been updated in January 2015. All staff spoken with had an appropriate understanding of what to do in the event of any safeguarding concerns and were aware of the practice policy and procedure which was available in folder form and on the desktop of staff computers. Staff were also aware of their responsibilities to share information and properly record documentation of any safeguarding concerns.

The practice had appointed a lead GP for safeguarding and a deputy and staff we spoke to were able to tell us who they were. They had been trained to the appropriate level three and were able to demonstrate knowledge to fulfil this role.

There was an alert system on the electronic patient record to highlight vulnerable patients such as those with learning disabilities, those who lived alone and children on the protection register. We saw examples of patients who had been identified as vulnerable and living alone and those with mental capacity issues who may require help from their families when making decisions.

A chaperone policy was in place and visible in the waiting rooms. (A chaperone is a person who acts as a safeguard and advocate for a patient and health care professional

during an intimate medical examination or procedure). Nurses were used to chaperone patients where possible and understood their responsibilities in this regard. Some administration staff had been used to chaperone patients in the past when required, but they did not have the required Disclosure and Barring Service (DBS) checks and had therefore been removed from this duty. The practice assured us they would not be used for this duty unless the appropriate checks were undertaken.

Medicines management

At our inspection in May 2014 we found the practice were non-compliant in the management of medicines. At that time there was no cold chain policy for the storage of medicines and the procedure was not followed for the recording of fridge temperatures. ("Cold chain" refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the client.) The recorded fridge temperature readings at the time of our last inspection were too high and no action had been taken to report or address it which could have compromised patient safety.

Following our last inspection, the practice manager had shared our findings with the other practices in the Clinical Commissioning Group (CCG) in an effort to improve cold chain management throughout the entire CCG. During this inspection we found that the practice had introduced a robust policy for vaccine storage and handling. This provided information to staff in the event of refrigerator failure or disruption of the cold chain. We were satisfied that staff responsible for maintenance of the cold chain understood their responsibilities and were aware of what to do in the event of any issues.

We checked medicines stored in the refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check all medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. None of the nursing staff we spoke with were qualified as independent prescribers.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Following our previous inspection, 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 had established a service for patients to pick up their dispensed prescriptions at nominated locations of their choice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. An incident had occurred in relation to this service which had been managed well by practice staff to ensure that the impact on patients was reduced as much as possible.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Regular checks were made by the cleaning company employed by the practice to ensure that the cleanliness was maintained.

The practice had a team responsible for the prevention and control of infection which included one of the GPs, the assistant practitioner and the practice manager. There was a policy and procedure in place with links to other policies such as patient isolation and the use of personal protective equipment such as disposable gloves and aprons. The curtains in treatment rooms were not disposable and the practice manager told us that these were laundered in house at least every six months. However, there was no record of this so it was not possible to tell when this had last been done.

Staff received induction training about infection control specific to their role and received annual updates. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks, such as running the water in the shower for one minute every day, in line with this policy to reduce the risk of infection to staff and patients. A company had been brought in to carry out an assessment of legionella. It had recommended actions and the practice had a plan to deal with the recommendations.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as spirometers, blood pressure measuring devices and fridges.

Staffing and recruitment

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

We looked at five staff files and found that most of the required recruitment checks such as proof of identification, qualifications, registration and criminal records checks through the DBS had been undertaken. In two of the files we did not see references. One of these had been for a nurse recruited in August 2012 and the other an administrator recruited in August 2014. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff which included making sure that references were obtained.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place to ensure that there were enough staff on duty each day. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's planned and unplanned leave.

We saw that there was a large complement of administration, reception, nursing and medical staff. Staff we spoke to were happy that there were usually enough of them to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was responsible for health and safety within the practice. Risk assessments were carried out when required and we saw an example of one undertaken for a pregnant member of staff. We also saw assessments on staff to see whether they required a DBS check.

There was also a system to manage clinical risks, such as patients missing appointments. We saw how missed appointments were monitored and some patients (if felt at risk) were telephoned to check the reason for their non-attendance. Mental health registers flagged patients in crisis and risks to staff (such as information not to visit a patient alone) was recorded.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff received training in basic life support and CPR three yearly and clinicians were trained every eighteen months. The practice were advised that this training should be undertaken annually to keep abreast of any changes that may be made in the interim.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. One member of staff we spoke with, although

Good

Are services safe?

trained in the use of the defibrillator, did not feel sufficiently confident to use it and said they would call for a member of the nursing or medical team in the event of emergency. The practice staff described a recent emergency when a receptionist had been concerned about a patient and emergency action had been required. The reception, medical and nursing staff had responded quickly and saved the patient from cardiac arrest which would have resulted if staff had not intervened.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had carried out an independent fire risk assessment which had identified actions required to maintain fire safety. At the time of our inspection the actions, including replacement of fire extinguishers and fire blankets had not been undertaken although the practice had agreed with the company that the work should go ahead. Following our inspection we checked the impact with the company who carried out the assessment. They were due to replace the equipment within days of our conversation and we were satisfied that any risk had been negated.

Good

Are services effective?

(for example, treatment is effective)

Our findings

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Clinicians spoken with provided evidence where new guidelines were disseminated and implications on patients were discussed. If actions were required these were agreed and implemented. Staff spoken with explained how these actions ensured that each patient received support to achieve the best health outcome for them. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as orthopaedics, diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs discussed shared stories about patients and discussed best practice with each other. Nurses supported each other and shared best practice.

We looked at data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic, hypnotics and non-steroidal anti-inflammatory prescribing which were comparable to similar practices. The practice had reviewed its population and identified patients with a diagnosis of dementia and checked that they were receiving the appropriate care and treatment they required. We saw the process the practice used to review patients at risk who missed appointment and also patients recently discharged from hospital who may require follow up.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients to secondary services. Regular review of referrals was discussed and improvements to practice were shared with clinical staff.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The practice manager and other staff we spoke to were able to evidence that clinical audits were undertaken in order to improve outcomes for people. We saw

minutes from meetings which had taken place to support decisions about clinical effectiveness. Information from these meetings was disseminated to staff and practice was changed when required.

The practice showed us two clinical audits undertaken during 2014/15. One of those checked that patients receiving an antibiotic were prescribed one of choice according to the current Tameside and Glossop CCG local antibiotic prescribing guidelines. The aim was to achieve 90% appropriateness in the prescribing of antibiotics and the results recorded, discussed and reaudited.

Following the previous CQC inspection the practice changed their systems to ensure that all GPs documented their own visits and a review had been done to ensure documentation was maintained to a high standard. Overall it was found that the results were excellent.

Other audits through the year of 2014/15 included a re-audit of medicines prescribed, a review of patients attending hospital respiratory departments and identification and review of dementia patients prescribed anti-psychotic medication. We saw that the practice had an ongoing plan of clinical audit throughout the year, many which were linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. One of the practice nurses confirmed they did their own clinical audit in relation to cervical screening. They then shared the information with other practice staff and all staff responded to any feedback received.

Effective staffing

There was a large complement of practice staff which included medics, nurses, support staff, managers, administrators and receptionists. We looked at staff

Good

Are services effective?

(for example, treatment is effective)

training records and saw that staff were up to date with most mandatory courses such as fire, information governance, safeguarding and infection control. They had also undertaken other guidance relating to their specific roles such as alcohol training, diabetes in adults and children, vaccinations and Gold Standards Framework (GSF). GSF is a way of working adopted by GP practices which involves them working as a team with other professionals in hospitals, hospices and specialist teams in order to provide the highest standard of care possible for patients and their families). There was a good skill mix among the GPs with some having additional diplomas and other interests such as orthopaedic medicine and minor surgery.

All staff undertook 360 degree annual appraisals which provided positive feedback and any negative issues that needed to be addressed. Staff we spoke with said they found this effective and training needs could be identified. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. One of the nurses was undertaking training to be a prescriber and administration staff received training so that they could cross cover each other. As the practice was a training practice, doctors who were training to be qualified as GPs were extra time during patient appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Working with colleagues and other services

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

The practice was commissioned for several enhanced services such as NHS health checks for patients over the age of 40. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). There was a process was in place to follow up patients discharged from hospital. All patients over the age of 75 who were discharged from hospital were reviewed by the practice over 75s team, all discharge summaries and prescriptions were acted on by the GPs and contact was made with discharged patients if necessary. The practice undertook yearly audits of patients follow up appointments at hospital departments such as respiratory and rheumatology to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings on a regular basis to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice made most routine referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use and was mostly effective for the patients. There was a system in place to deal with emergency attendances at accident and emergency and non-routine referrals and patients received a referral letter written or typed by their GP to take with them to their appointment.

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

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that medical and nursing staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it but no formal training had been undertaken. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, for example with making do not attempt cardiopulmonary resuscitation orders, we saw that staff understood their role. We were shown evidence that patients were supported to make their own decisions where possible and that best interest meetings or consultation with families took place where patients had capacity issues. We spoke with staff from nursing homes attached to the GP practice who confirmed that support such as this was provided to the patients of the practice living at the homes.

Patients with a learning disability, complex needs and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Care plans were set up with the patient at the surgery or at their own home if they were housebound. Plans were reviewed annually or when otherwise necessary and families and advocates were included if required.

We spoke with nursing staff who told us there was a practice policy for documenting consent for specific interventions such as ear syringing or minor procedures and verbal consent was taken for all other treatments. Nursing and clinical staff understood the different types of consent such as informed and implied and were aware of their responsibilities for obtaining consent from children. All the patients we spoke with said they were asked for their consent before treatment.

Health promotion and prevention

The practice discussed the needs of the patients in the community identified by the Joint Strategic Needs Assessment (JSNA) with the CCG. The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. We saw information from the JSNA which described treatment and commissioning requirements about all of the population groups. Albion Medical Practice had tendered a bid and been accepted to offer an enhanced service specifically to patients over the age of 75 and had now employed a core team to undertake this intense service.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. GPs used their contact with patients to help maintain and improve health and wellbeing by offering opportunistic advice on smoking cessation or diet. Patients with medical conditions such as high blood pressure, heart problems, asthma and diabetes were encouraged to attend the practice annually to ensure the treatment they were receiving was effective.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse. Patients were encouraged to attend and extra clinic sessions were set up.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. They encouraged patients to attend health checks through their newsletter and there was excessive information displayed in patient waiting area. Due to the large amount of leaflets and posters displayed some important information was lost in the myriad. A member of the patient participation group (PPG) that we spoke with suggested that making the displays more informative was an action they could deal with. We fed our findings back to the practice staff who agreed this was something that could be improved.

Good

Are services caring?

Our findings

Respect, dignity, compassion and 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. We were able to observe patients waiting for appointments and we saw that staff showed empathy and were respectful throughout discussions. Patients spoke highly of the practice, the reception staff and the doctors. One patient we spoke with told us they had been with the practice more than 40 years and had always been more than happy with the service.

Privacy during discussions was maintained and there was a place where patients could speak to reception staff in private if they wished to. The practice switchboard was located away from the reception desk and was shielded which helped keep patient information private. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Most patient satisfaction feedback was positive. We reviewed the most recent data available for the practice which included information from the national patient survey 2015. 85% of patients who responded said they found reception staff helpful. When asked through the practice's own patient survey if they were treated with dignity and respect by the staff, only one response out of 71 was negative. Only three patients completed CQC comments cards to tell us what they thought about the practice but their responses were positive.

We saw that consultations and treatments were carried out in the privacy of a consulting room and conversations could not be heard through closed doors. Curtains were provided in consulting rooms and treatment rooms so that privacy and dignity was maintained during examinations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. 87% said the last GP they saw or spoke with was good at explaining tests and treatments and 81% said they were involved in decisions about their care and treatment. There was an ethos of "self-responsibility" and people were encouraged to support and help themselves.

Patients we spoke with told us that their health issues were discussed with them and they felt well informed by the clinicians and were encouraged to be involved in decisions about their treatment. They also said they felt listened to and support by staff and had sufficient time during consultations. When asked, patients said if they needed longer time with the GP then it was possible to book longer appointments.

All staff spoken with were effective in communication and knew how to access Language Line which is a worldwide telephone interpretation service. They also used other staff more familiar with certain patients, to help deal with any communication issues. This included information about appointments, services provided by the practice and health promotion advice. Literature was available in different languages if and when required. We saw that patients' information was treated with confidentiality and that information was shared appropriately when necessary using the correct data sharing methods.

Patient/carer support to cope emotionally with care and treatment

One patient we spoke with went into great detail telling us about the support received following the death of their partner, and further emotional support provided to them and their family when needed at another time. We saw that patients were signposted to many support services such as bereavement and patient liaison services.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. However there was a great deal of information and it was not easy to find what was being looked for.

The practice's computer system alerted GPs if a patient was also a carer. Concerns about a patient with learning disabilities prompted referrals to a dietician and the adult learning disability team. Both the patient and the parents/carers received ongoing support and management and the patient's physical and mental health and wellbeing were

Good

Are services caring?

improved. We saw the written information available for carers to ensure they understood the various avenues of support available to them and there was a section for carers on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

We saw that the practice engaged regularly with Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where these had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Actions included employment of a core group of clinicians to manage the Over 75s project, "Going for Gold" (Gold Standards Framework) team training to further enhance the care provided to patients at the end of their lives and agreement with other Ashton Practices to have dedicated nursing homes per practice to enhance the quality and continuity of care provided to those patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) such as better car parking facilities, early opening and automatic doors.

Tackling inequity and promoting equality

The practice did not have a large diversity in its population but had recognised the needs of different groups in the planning of its services. This included vulnerable people, people with learning or mental health disabilities and the unemployed. The practice manager told us there were no homeless patients registered at the practice. However, they had a good understanding of the difficulties faced by homeless patients trying to access a GP and they knew the process to follow so homeless patients could access GP and other services.

Staff had access to telephone translation services if they were required. Staff had not received equality and diversity training but reception and administration staff had undertaken "how to deal with patients" training which covered different scenarios they might face.

The premises and services had been adapted to meet the needs of patient with disabilities and new automatic doors were being installed. The building had three levels, the lower being by the nursing staff. Wheelchair access was available to the nurse consulting rooms through a back lower level entrance. We saw that the reception area was spacious enough for wheelchairs and patients with prams. The top level of the practice was not used by patients.

Access to the service

The practice was opened Monday to Friday between 8am and 6pm. On Wednesdays they were open later until 7.30pm and on Thursday mornings earlier from 7am. On a Thursday afternoon the practice closed for training. Telephones were answered until 6.30pm every day and until 7.30pm on a Wednesday. Clinics included minor surgery, medical examinations, family planning, child health services, substance and alcohol misuse, young people's and mental health services.

Staff showed us how the appointment system was easy to use and supported access and choice. Most patients said they did not have problems accessing the service although there was some negative feedback received. Patients spoken with reported that they always managed to get an emergency appointment if required.

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

The practice had set up an arrangement with other practices in Ashton and were in the process of providing nursing homes with dedicated GP practices to give better quality and continuity of care to the patients residing there. Albion Medical Practice were responsible for two nursing homes and we spoke to the registered managers at those homes. They told us about the positive impact this service had for the patients and encouraged all new patients to register with the dedicated practice. Patients who did not want to change their GP continued to use their own. Both

Good

Are services responsive to people's needs?

(for example, to feedback?)

homes now had more than half their residents registered with the dedicated practice. The positive feedback included continuity of care, better understanding, good working relationships with familiar staff and a tendency by the patients to be more open and willing to talk about their concerns.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system such as posters displayed, a summary leaflet and information on the practice website. Patients we spoke with were aware of the process to follow and most said they would speak to the practice manager or a receptionist if they had any concerns.

We looked at the 15 complaints received in the last 12 months and found they were dealt with satisfactorily. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. The practice had changed its policies and procedures as a result of complaints if necessary and we saw they were discussed at team meetings to ensure all staff were able to learn and contribute to any improvement action.

Are services well-led?

Good

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

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