Monarch Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Monarch Medical Centre on 19 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate.

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.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand, however there was no evidence of the system being put into practice.
- Patients provided varied feedback on accessing appointment, with a number of patients reporting difficulties getting through to the practice by telephone, however patients reported when they got appointments these were convenient.
- 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.

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

Importantly the provider should

- Ensure all staff receives regular refresher safeguarding training.
- Ensure staff acting as chaperones receive appropriate training and procedures follow professional guidance.

Summary of findings

- Ensure none clinical staff have access to appraisals on an annual basis.
- Have systems in place to formally gather and act on the views of patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated via team meetings 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 the same or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for clinical staff however appraisals were out of date for non clinical staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

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 England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice 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.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about

Summary of findings

the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions and attended staff meetings, however not all staff had received annual appraisals.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the population group of older people. 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, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice was responsive to the needs of older people, the GPs and nurse provided home visits with rapid access appointments for those with enhanced needs.

The practice had achieved 76% vaccination rate for the influenza vaccine for those over 65, just above the local average.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so their condition could be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2013/14 showed 100% of the outcomes had been achieved for patients with asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average.

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

A contraceptive service was available which included counselling for option such as long acting reversible contraception such as implants and coils.

Summary of findings

Babies are seen in the assessment clinic run by the health visitor and doctor for all babies between the ages of 6 – 8 weeks. Immunisation rates were high for all standard childhood immunisations, where children and babies failed to attend for immunisations they would be followed up by the practice nurse.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75.

Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments. If patients could not be seen in surgery at a convenient time they would be offered an appointment at Healthier Radcliffe (extended hours) initiative 6pm to 8pm weekdays or weekends and bank holidays. Telephone consultations were also available to patients who could not attend the practice.

Students are given advice on how to stay healthy away from home; this included being offered the Meningitis C vaccine and MMR vaccines if they did not have them when they were babies.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services. For children and young people, referrals where made the child and adolescence mental health service. If patients required urgent care including children and young people, they would be referred to the Access & Crisis Team.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with eight patients. We reviewed 47 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 89% described their overall experience of this surgery as good and 98% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

We spoke with the GP who was the safeguarding lead, they had recently completed adult safeguarding training, however they required refresher training on child protection. All other staff provided evidence and examples of having a clear understanding of their safeguarding responsibilities, but would benefit from regular refresher training to ensure they are following the most up to date procedures. The practice manager told us they would arrange updates and training immediately following our inspection .

Chaperones were available for patients with the nurse in the main acting as the chaperone. Where the nurse was not available reception staff took on the role of chaperone. Speaking with reception staff they told us they had not received any formal training and when acting as a chaperone they would stand outside of the dignity curtain.

At the time of our inspection the practice nurse was retiring within the month, a recruitment process was on-going, however we found no strategy or succession plan was in place to fill the gap which would be left once the practice nurse left and the successful recruitment of a new nurse. We also noted one GP was due to take a year away from the practice; again there were no plans in place to replace the GP. The practice had an appraisal system in place for all staff; however appraisals were not up to date for non-clinical staff.

The practice did not have a patient participation group or any formal system in place other than a complaint procedure to gather patient feedback.

Monarch Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice manager and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Monarch Medical Centre

Monarch Medical Centre provides primary medical services in Radcliffe, Bury from Monday to Friday. The practice is open between 8.00am – 6.00pm Monday to Friday. The practice operate an open surgery on Monday mornings, all other day appointments are required by telephoning the practice. The practice have extended hours as part of Healthier Radcliffe initiative, in which six GPs have come together to offer appointments to patients, 6pm to 8pm week days and 8am until 6pm during the weekend and bank holidays.

Monarch Medical Centre is situated within the geographical area of NHS Bury Clinical Commissioning Group (CCG).

The practice has a GMS contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Monarch Medical Centre is responsible for providing care to 3700 patients of whom, 52% were male and 48% were female. Patients are from the fourth most deprived decile with 19% black and minority ethnic (BME) patients.

The practice consists of three GPs, two male and one female and a practice nurses. The practice was supported by a practice manager, receptionists and secretaries.

When the practice is closed patients were directed to the out of hours service.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 19 May 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with eight patients and nine members of staff. We spoke with a range of staff, including the GPs, practice manager, practice nurses, health care assistants and reception staff.

Detailed findings

We reviewed 47 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and spoke with staff which confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, including regular contact with other health and social care professionals where required. We saw a system was in place to ensure reviews took place in a timely manner for patients who required annual reviews as part of their care;

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training, and self-directed learning and attending monthly learning events.

Reliable safety systems and processes including safeguarding

The staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure; we noted however there was no reference to the Mental Capacity Act 2005 within the adults safeguarding policy. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead, they had recently completed adult safeguarding training, however they required refresher training on child protection. All other staff provided evidence and examples of having a clear understanding of their safeguarding responsibilities, but would benefit from regular refresher training to ensure they are following the most up to date procedures. The practice manager told us they would arrange updates and training immediately following our inspection.

Chaperones were available for patients with the nurse in the main acting as the chaperone. Where the nurse was not available reception staff took on the role of chaperone. Speaking with reception staff they told us they had not received any formal training and when acting as a chaperone they would stand outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.'

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

The nurse 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 the nurse had received appropriate training to administer vaccines.

Good

Are services safe?

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. The practice worked alongside the CCG medicines management team who visited the practice to look at prescribing within the practice and audit medicines such as antibiotics and Benzodiazepines to support the practice in ensuring they are following up to date prescribing guidance.

The practice had identified a higher than average number of patients had been prescribed Benzodiazepine, for long periods of time, which can lead to addiction. Benzodiazepine should be prescribed for short periods to ease symptoms of anxiety or sleeping difficulty. As a result the practice was working with patients on a reduction programme and offering patients the support of an external drugs counsellor to support them to reduce and ultimately cease taking the medication. We saw from data a continual decrease in prescribing Benzodiazepine.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. A GP took the lead for infection control.

Cleaners were employed by the practice who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. We looked in several consulting rooms, including the minor surgery room. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw fabric dignity curtains were used and we were told these were routinely removed and cleaned on a six monthly basis.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single patient use instruments, we saw these were stored correctly and stock rotation was in place.

Equipment

The practice manager ensured all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

A panic alarm system was in place in consulting rooms and behind reception for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for

employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of two staff. We saw in records checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

At the time of our inspection the practice nurse was retiring within the month, a recruitment process was on-going, however we found no strategy or succession plan was in place to fill the gap which would be left once the practice nurse left and the successful recruitment of a new nurse. We also noted one GP was due to take a year away from the practice; again there were no plans in place to replace the GP.

Monitoring Safety & 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. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice manager had responsibility for all maintenance contracts and risk management associated with the building. We saw that data sheets were not in place for Control of Substances Hazardous to Health (COSHH), we raised this with the practice manager who told us they would address this immediately following our inspection.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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.

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.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

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

Records showed that staff were up to date with fire training and regular fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse 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. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurse that they completed thorough assessments of patients' needs in line with NICE guidelines.

The nurses we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed, all clinical and public health outcomes had been achieved above the local CCG and national average. For example 100% of outcomes for patients with asthma or Chronic obstructive pulmonary disease (COPD) had been achieved.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks and annual reviews. For patients with learning disabilities or poor mental health again the practice had achieved 100% of outcomes higher than the local or national averages.

The nurse carried out annual physical health reviews for patients diagnosed with mental health needs including those with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF 2013/14 provided evidence the practice were responding to the needs of people with poor mental health, above the average of the local CCG, by ensuring for example they had a comprehensive care plan documented in the record and patients had access to health checks as required such as, a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurses told us they received regular updates as part of their ongoing training.

Clinical staff were able to describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held monthly with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs and ensured that whenever possible patients die in the place of their choosing.

We were told for patients where English was their second language an interpreter could be booked in advance. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic Obstructive Pulmonary Disease (COPD).

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The practice nurse provided a range of examples of patient information leaflets they provided to patient to self manage conditions such as COPD and Asthma.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical audit

Good

Are services effective?

(for example, treatment is effective)

is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were shown a number of audits including minor surgery and patients with dementia on antipsychotic medication.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients with long term health conditions such as, asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 94% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained a high level of achievement with 99.8% of outcomes achieved above the local CCG and national average.

Patients told us they were happy the doctor and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nurse with a number having additional training and qualifications. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

The practice had an appraisal system in place for all staff; however appraisals were not up to date for non-clinical staff.

The practice nurse was expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and treating minor ailments.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they received updates and new guidance during team meetings and via memos. We saw the GPs and nurse had access to training as part of their professional development, attending training and monthly education events in which updates on key issues were provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Mutli-disciplinary meetings were arranged with other health and social care providers where required and communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax.

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

A substance misuse worker from the community Drug and Alcohol team provided monthly clinics at the practice for patients, working closely with GPs to monitor the health and social needs of patients.

Information Sharing

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

Good

Are services effective?

(for example, treatment is effective)

manner. Electronic systems were also in place for making referrals, the practice made 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.

We saw where required in emergency situations, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent for procedures such as minor surgery and incorporated a detailed consent form for patients to sign, however there was no policy in place which gave guidance to staff on areas such implied consent, how to obtain consent, consent from under 16's and consent for immunisations.

Speaking with staff they were clear about their responsibility to gain and where required record consent. We found that majority of staff were aware of the Mental Capacity Act 2005, the Childrens' Acts 1989 and 2004 and their duties in fulfilling it. Majority of clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). One GP had received training in relation to the MCA.

All clinical staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. Where capacity to consent was unclear staff would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

The practice had a range of written information for patients in the waiting area which could be taken away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. The

clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 60% of patients eligible to health checks took up the offer. The practice followed the guidance from the local CCG to ensure patients followed in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. The nurse actively referred patients to 'BEATS' which is a local exercise referral scheme.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 77% vaccination rate for the influenza vaccine for those over 65.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake was 81.2%, slightly lower than the local and national averages. There was a policy to follow up those who did not attend.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, details were passed onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with eight patients and reviewed 47 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at reception and a back office, staff told us and we observed, where any private conversations were required these were transferred to the back office to maintain privacy.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 94% of respondents found the receptionists at this surgery helpful above the local CCG average.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones and modesty sheets to maintain patient's dignity.

We found all rooms had dignity screens and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey 98% had confidence and trust in the last GP they saw or spoke to and 98% had confidence and trust in the last nurse they saw or spoke to.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 91% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; this was above the local and national average.

The practice had formal care plans in place for patients; they included care plans for vulnerable patients over 75 year of age, patients with poor mental health and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities, required an interpreter or multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 91% of respondents stated the last GP they saw or spoke to was good at listening to them, 94% say the last GP they saw or spoke to was good at giving them enough time and 96% said the last nurse they saw or spoke to was good at giving them enough time.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team.

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.

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as, opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

The practice supported asylum seekers by providing an enhanced service, allowing the practice to offer additional time and resource to asylum seeking patients to enable them to establish a baseline of clinical history and health care needs. Where required routine appointments will be extended to allow for language difficulties and the use of interpreters.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice did not have a patient participation group or any formal system in place other than a complaint procedure to gather patient feedback. We were told patients were open with practice staff and any issues/ concerns or suggestion patients were able to speak directly with the practice manager.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or those who required an interpreter.

The majority of the practice population were English speaking patients, for those patients who were Urdu speaking the GPs were able to translate, for all other non-English speaking patients a translation service was available.

The practice was over two floors with patients accessing services on both floors. For those patients unable to negotiate the stairs they would be seen within one of the ground floor consulting rooms. The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing facilities.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice participated in an extended hours scheme where patients could access appointment at a nearby health centre evenings and weekends.

Access to the service

The practice is open between 8.00am – 6.00pm Monday to Friday. The practice operate an open surgery on Monday mornings, all other day appointments are required by telephoning the practice. The practice have extended hours as part of Healthier Radcliffe initiative, in which six GPs came together to offer appointments to patients, 6pm to 8pm week days and 8am until 6pm during the weekend and bank holidays.

Appointments with the nurse were available Monday to Friday and could be pre booked.

Patient's views on the appointment system varied with many patients happy with the system. We saw from the GP national survey 88% were able to get an appointment to see or speak to someone the last time they tried. 97% say the last appointment they got was convenient and 83% were satisfied with the surgery's opening hours above the local CCG average.

Comprehensive information was available to patients about appointments on the practice website. This included information about the appointment system and home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed, this information was detailed on the practice website. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learnt were shared with staff at team meetings.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so, speaking with reception staff they told us any verbal complaints or issues they felt could be resolved informally they would give patients the option of speaking with the practice manager at the time to resolve any concerns.

We saw where patients left comments on NHS choice, be they positive or negative the practice responded. Where comments constituted complaint patients were invited to put this in writing or contact the practice manager.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice statement of purpose. The practice aims and objectives included: 'To provide a high standard of medical care, be courteous, approachable, friendly and accommodating and through monitoring and auditing continue to improve our health services'. We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with eight members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

We noted there was no strategy or succession plan in place to fill the gap which would be left once the practice nurse left to ensure safe staffing levels to meet the needs of patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control and a GP partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them, to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF 2013/14 data for this practice showed it was performing in line with national standards achieving 100% of outcomes, above the local and national average.

The GPs met on a daily basis to discuss patient care and seek advice and guidance from colleagues. The practice manger and GPs met regularly to discuss practice issues, practice development, however these were not minuted. The practice manager met regularly with the administration team and meetings were held at times which would maximise attendance as majority of staff were part time, staff told us they felt engaged and able to discuss any issues or concerns during meetings and actions were agreed, however these formal meeting were not minuted. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted individual clinical audits, in which outcomes were shared to monitor quality and share learning.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out for the practice by an external organisation in which recommendations had been made; however there was no action plan to follow up on the recommendations. We also noted there were no data sheets or risk assessments in place for Control of Substances Hazardous to Health (COSHH).Leadership, openness and transparency

The GPs met daily. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures, for example, a recruitment policy and induction programme were in place to support staff.

We were shown evidence that staff as part of induction had access to policies and procedures and all staff were able to

Are services well-led?

Good

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

access policies and procedure via the policies and procedure file, located in the office, which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 89% described their overall experience of the practice as good and 84% would recommend this surgery to someone new to the area, both above the local CCQ average. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services). We saw for March 2015, out of 15 responses, six selected extremely likely, four selected likely and one selected extremely unlikely that they recommend the GP practice to friends & family if they needed similar care or treatment.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities; however appraisals were not up to date for non-clinical staff.

The practice had reviewed significant events and other incidents and shared with staff informally.