

# Shekar et al

## Quality Report

Moorgate Primary Care Centre  
22 Derby Way  
Bury  
Greater Manchester  
BL9 0NJ

Tel: 0161 447 8281

Website: [www.mindenfamilypractices.org.uk](http://www.mindenfamilypractices.org.uk)

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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

### Summary of this inspection

Overall summary	2
The six population groups and what we found	4
Areas for improvement	5

### Detailed findings from this inspection

Our inspection team	6
Background to Shekar et al	6
Detailed findings	7

## Overall summary

### Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection, 12 May 2015 the overall rating was Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. While there was evidence to demonstrate the practice staff had learned from incidents and changed their practices and improved their processes, there were some areas that needed improvement. For example, in light of there being over 7,000 patients registered with the practice, there was a low number of significant events recorded. This meant that issues were possibly not being identified for the purpose of reviewing and improving the quality of the service.
- The practice carried out regular clinical audits to review the effectiveness and appropriateness of the care it provided and to ensure that care and treatment was delivered according to evidence-based guidelines. A plan of future audits was not in place and we found that clinical audits could be improved upon with more focus on patient outcomes.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

# Summary of findings

- Staff were well supported and supervised.
- Patient feedback about the service was overwhelmingly positive.
- A member of the non-clinical staff acted as a cancer and carers champion.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The six population groups and what we found

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

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

# Summary of findings

## Areas for improvement

### Action the service **SHOULD** take to improve

- Clinicians should consider how they identify and manage patients with severe infection by for example, using the risk stratification tool as recommended by The National Institute for Health and Care Excellence (NICE) guidelines to identify and manage patients with severe infections, for example, sepsis.
- GPs should have a system to identify patients referred on the two week wait referral pathway who had not been seen.
- The way significant events are managed should be reviewed for the purposing of ensuring staff know how to identify significant events in order to learn from these incidents and minimise the risk of them reoccurring.
- Written and verbal complaints received should be logged and reviewed for themes and trends..

# Shekar et al

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC inspector and included a GP specialist adviser.

### Background to Shekar et al

Moorgate Primary Care Centre, 22 Derby Way, Bury, Greater Manchester BL9 0NJ is located in Bury town centre, within the Bury Clinical Commissioning Group.

The practice is responsible for providing treatment to 7661 patients.

The age profile of the practice population is broadly in line with the CCG averages. Information taken from Public Health England placed the area in which the practice is located as fourth on the deprivation scale of one to ten. (The lower the number the higher the deprivation). In general, people living in more deprived areas tend to have greater need for health services.

# Are services safe?

## Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

### Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration of most staff where relevant, on recruitment. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, reception staff who acted as chaperones had not completed a DBS check. There was no risk assessment in place to explain why a DBS check had not been undertaken. After the inspection we were informed that a DBS check had been carried out for the reception staff who acted as chaperones.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Clinical staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

### Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for newly recruited staff which was tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.

Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Receptionists were trained on how to identify patients who may be acutely ill with GPs available for advice when necessary. The practice had access to a microbiologist laboratory and GPs had audited antibiotic use. An incident of sepsis from another Minden Family practice had been discussed as a significant event although not discussed at a clinical meeting within the practice. While GPs demonstrated they were aware of clinical signs, we did not see evidence of any training or sepsis resources that could be accessed, for example, the risk stratification tool as recommended by The National Institute for Health and Care Excellence (NICE) guidelines to identify and manage patients with severe infections such as sepsis.

### Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- There was a record of patients who had been referred on the two week wait referral pathway. There was no

# Are services safe?

system to check that patients had been seen when referred through this system. GPs only followed up patients who had not attended their two week wait hospital appointment when they were notified by the hospital. There were no systems to identify referred patients who had not been seen.

## Safe and appropriate use of medicines

The practice had some systems in place for appropriate and safe handling of medicines but some of these required improvement.

- The systems for managing medicines, including vaccines, oxygen, and emergency medicines and equipment minimised risks. Liquid nitrogen was kept at the practice. This was stored in a clinical room that was kept locked outside of patient consultations and patients were not left alone in the room during treatments. The nitrogen container did not have a lock fitted to the handle to ensure its safe use. After the inspection we were informed that the liquid nitrogen had been removed from the premises until alternative arrangements were made for its use.
- The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- We looked at the emergency response trolley and found emergency medicines were kept in line with good practice.

## Track record on safety

Specific health and safety assessments concerning the building and facilities were held centrally by the building management team and regularly monitored and updated if required.

The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. However, we found improvements were needed in some areas. For example, safety alerts could be improved by demonstrating what actions had been taken to address any required changes to practices.

## Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events for reviewing and investigating when things went wrong. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The significant events recorded were well written although staff found these difficult to locate on the day of the inspection. Significant events were discussed every 3 months with a record kept of actions recorded. We found that staff learning had not always been recorded, although we did see evidence of changes to practice in one area.
- In light of there being over 7,000 patients registered with the practice, there was a low number of significant events recorded. This meant that issues were possibly not being identified for the purpose of reviewing and improving the quality of the service.
- There was a system for receiving and acting on safety alerts. However, a log of these alerts was not kept and we saw no evidence of who had seen the alerts and what action had been taken to address any required changes.



# Are services effective?

(for example, treatment is effective)

## Our findings

We rated the practice, and all of the population groups, as good for providing effective services.

### Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Data showed that the practice was a lower prescriber of hypnotic drugs than the CCG and national averages. (Hypnotic drugs are a group of drugs that reduce anxiety, aid sleep or have a calming effect)

Prior to the inspection the practice sent us evidence of an audit of prescribing antibiotics for patients presenting with a cough. This was a two cycle audit that showed improvement to patient outcomes.

- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support. Information was also available on the practice website.

#### Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

#### People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long term conditions had received specific training.

#### Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The uptake rates for the vaccines given were in line with the national target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

#### Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 91%, which was above the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

#### People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances those with a learning disability.

#### People experiencing poor mental health (including people with dementia):

- 92% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months; CCG average - 88%; national average - 84%.

# Are services effective?

## (for example, treatment is effective)

- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months; this was the same as the CCG average; national average - 89%
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 89%; CCG average - 92%; national average - 89%; and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation was 95%; this was the same as the CCG and national average.

### Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results (2015/2016) were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95%. The overall exception reporting rate was 0% compared with a national average of 5% and the national average of 6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c was 64 mmol/mol or less in the preceding 12 months was 82%; this was the same as the CCG average; national average - 78%
- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who were treated with anti-coagulation drug therapy was 100%; CCG average - 96%; national average - 87%.

### Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles through discussion of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

### Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Referrals were carried out as necessary when patients moved between services or when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

### Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

# Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

## Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

# Are services caring?

## Our findings

We rated the practice, and all of the population groups, as good for providing caring services.

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 22 Care Quality Commission comment cards. Eighteen of the patient comment cards we received were very positive about the service experienced, 4 patients commented they found it difficult to get an appointment with a GP of their choice. This was in line with the results of the NHS Friends and Family Test which indicated patients were mostly 'extremely likely' and 'likely' to recommend the practice to their friends and family.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 302 surveys were sent out and 115 were returned. This represented 1.5% of the practice population. The practice was in line with and above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) and national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG and national average - 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 96%.
- 91% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 86%; national average - 86%.

- 98% of patients who responded said the nurse was good at listening to them; CCG and national average - 91%.
- 98% of patients who responded said the nurse gave them enough time; CCG and national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG and national average - 97%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 96% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

### Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception area informing patients this service was available although this was only in English.
- None of the information displayed in the patient waiting area was in any other language than English.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. This information was logged in patient's records. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 73 patients as carers (1% of the practice list). A member of staff acted as a cancer and carers' champion to help ensure that the various services supporting carers were coordinated and effective.

## Are services caring?

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 91% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.

- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG and national average - 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG average - 86%; national average - 85%.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

### Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments).
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered to patients, for example baby changing facilities were available and there was a pharmacist located on the ground floor of the building.
- The practice made reasonable adjustments when patients found it hard to access services. For example, longer appointments were available for patients with a learning disability and a member of staff contacted their carers to ensure they had all the information they needed with regard to their appointment.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

#### Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also carried out home visits for those who had difficulties getting to the practice due to limited local public transport availability.

#### People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings to discuss and manage the needs of patients with complex medical issues.

#### Families, children and young people:

- We found there were systems 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 accident and emergency attendances.
- All parents or guardians calling with concerns about a child under the age of 12 were offered a same day appointment when necessary.

#### Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, mid-week extended opening hours in the evening.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

#### People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Staff had recently updated their training on domestic violence and contact details of support agencies were available.

#### People experiencing poor mental health (including people with dementia):

- Patients on the mental health register were invited for an annual review of their physical and mental health. Their care plan was reviewed to ensure that it remained appropriate.

# Are services responsive to people's needs?

## (for example, to feedback?)

- A comprehensive care plan was produced for all patients with dementia which was reviewed on an annual basis.

### Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. 302 surveys were sent out and 115 were returned. This represented 1.5% of the practice population.

- 96% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 84% and the national average of 80%.
- 82% of patients who responded said they could get through easily to the practice by phone; CCG – 69%; national average – 71%.
- 85% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG – 78%; national average – 75%.

- 89% of patients who responded said their last appointment was convenient; CCG – 84%; national average – 81%.
- 81% of patients who responded described their experience of making an appointment as good; CCG – 74%; national average – 73%.
- 76% of patients who responded said they don't normally have to wait too long to be seen; CCG – 62%; national average – 58%.

### Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. However, patients had to ask a member of the reception staff for a copy of the complaint procedure as this was not displayed in the patient waiting area.
- The complaint policy and procedures were in line with recognised guidance. Pre inspection data indicated that 6 complaints were received in the last year. We reviewed a selection of these complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, we looked at the records of a complaint about a GP attitude. There was evidence that the GP had reflected on their manner and agreed to some issues raised by the complainant.
- We were told that complaints were not monitored for trends and verbal complaints were not logged.



# Are services well-led?

Good 

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

## Our findings

We rated the practice, and all of the population groups, as good for providing well led services

### Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. .
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

### Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

### Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

### Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. However, we noted that there were shortfalls in some areas of the running of the practice. For example, clinicians did not always use the risk stratification tool as recommended by The National Institute for Health and Care Excellence (NICE) guidelines to identify and manage patients with severe infections, for example, sepsis. Also, reception staff who acted as a chaperone had not always completed a Disclosure and Barring Service check.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control



# Are services well-led?

Good 

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

- Practice leaders had established policies, procedures which ensured the safety of the staff and patients.

## Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, a recent infection control audit had been completed. This audit showed that infection control was well managed at the practice.
- There was an information management and technology lead. Their role was to manage the quality and performance of the practice. They kept GPs informed of risks, issues of concern and the practice's performance. The Business Development Partner took overall responsibility and accountability for, amongst other things, continuous development, improvement and quality.
- The performance of employed clinical staff was monitored through supervision and appraisal. Practice leaders had oversight of incidents, complaints and MHRA alerts, although a log of these alerts was not kept and we saw no evidence of who had seen the alerts and what action had been taken to address any required changes.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. A plan of future audits was not in place and we found that clinical audits could be improved with more focus on patient outcomes.
- The practice had plans in place and had trained staff for major incidents.

## Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

## Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients and staff views and concerns were encouraged, heard and acted on to shape services and culture. For example, regular team meetings were held for the staff so they had an opportunity to talk about the things that were important to them and there was an active Patient Participation Group (PPG) which met with staff regularly to discuss issues relating to patient care. We spoke with two members of the PPG who told us they received good support from the practice staff.
- The service was transparent, collaborative and open with stakeholders about performance.

## Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The practice was in the process of merging with a number of other practices in the Bury area. Staff and patients had been informed of ongoing developments through meetings and newsletters. This gave them an opportunity to ask questions about the way the newly formed service would be provided.
- There was a focus on continuous learning and improvement at all levels within the practice. The practice held regular learning events and a member of

# Are services well-led?

Good 

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

the nursing staff told us they were supported to attend individual training to support and advance them in their role. The practice employed administration staff on an apprentice scheme. These staff were offered full time employment at the end of their apprenticeship and further training so they could develop in their role.

- Staff took time out to review individual and team objectives, processes and performance.
- Reception systems had been overhauled following patient feedback.