Wellfield Medical Centre

Quality Report

Wellfield Medical Centre
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Wellfield Medical Centre on 23 June 2015. We found that the practice was rated as good overall.

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 were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well.

Are services effective?

Good

The practice is rated as good for effective. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for caring. Patients told us 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 saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. The practice reviewed the needs of its local population and engaged with NHS England and the local Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments

Summary of findings

available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. There was evidence that the practice had a culture of learning, development and improvement.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients over 75 had a named GP who was responsible for the overall co-ordination of their care. The practice provided home visits for this population group when required by the GPs and the practice nursing staff. This included providing immunisations and a phlebotomy service at home. Patients in this population were given extended appointments for chronic disease management conditions when required.

The practice worked in conjunction with the crisis team with the aim of reducing early admission to hospital for older people. There was a lift in the building to facilitate access to the upper floor for those patients with mobility problems.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions. The practice held chronic disease management clinics and had a recall system for six monthly reviews. There was also a process in place to contact those patients who do not attend.

Clinicians in the practice undertook regular audits of long term conditions to ensure the practice kept up with changes, the latest good practice standards and guidance. Local hospital consultants regularly visited the practice to give talks to the clinical team on the latest advancements in chronic disease management for patients. Nursing staff received regular updates on chronic disease management through the practice nurse forum.

The practice held quarterly multidisciplinary team meetings where patients on the palliative care register were discussed.

Families, children and young people

Good

The practice is rated as good for families, children and young people. There were weekly baby clinics with access to a nurse and a GP for child health surveillance and immunisations and a comprehensive family planning service. A full immunisation programme was undertaken by the surgery and delivered by the practice nursing team. There was a weekly clinic run by the community midwives and a clinic to deal with sexual health.

All staff had undertaken safeguarding children training to the appropriate level for their role. One of the GPs was the practice lead

Summary of findings

for Safeguarding. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had a child protection register and additional alerts that were triggered when entering the records of these patients in order to make all staff aware. Any new patients added to the child protection register were discussed at the weekly Tuesday clinical team meeting.

The practice had introduced new technologies such on-line booking for appointments and prescriptions with the aim of being more user-friendly for younger patients.

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. The practice recognised that working age patients may struggle to access routine surgery appointments within core hours, and therefore provided a variety of options to facilitate access.

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 and weight management. Access to NHS health checks were promoted to patients when the service was in the local area and this included national screening programmes such as bowel cancer screening.

Appointments and prescriptions could be booked online in advance. Telephone consultations were also available to patients who could not attend the practice.

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 held a weekly clinical meeting to discuss those patients with complex needs. There was also a monthly meeting at the surgery to discuss high risk patients and attendees included district nurses, social workers and/or advanced medical practitioners as required.

All staff had been trained to the appropriate level in safeguarding vulnerable adults and children, and also had an understanding of the mental capacity act.

Summary of findings

The practice had a child protection register and additional alerts that were triggered when entering the records of these patients in order to make all staff aware. Any new patients added to the child protection register patients were discussed at the weekly Tuesday clinical team meeting.

The practice nursing team undertook home visits for patients with physical disabilities when required.

Translation and interpreter services were available for patients whose first language was not English.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia).

The practice has a register of those patients with diagnosed mental ill health and those with dementia. The practice held a severe mental health clinic for those patients diagnosed with psychosis to ensure regular mental and physical health care reviews were undertaken. There was also a clinic for those patients diagnosed with dementia.

Any patients with a diagnosis of depression or anxiety were followed up by the practice every four weeks.

Medicines prescribed for a mental health related condition were not given on a repeat prescription.

All clinical staff we spoke demonstrated an understanding of the mental capacity act.

Summary of findings

What people who use the service say

We spoke with eight patients who used the service on the day of our inspection and reviewed seven completed CQC comment cards. The patients we spoke with were very complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect. The comments on the cards provided by CQC were also very complimentary about the service provided though patients did comment about having difficulties getting through to the practice by phone on occasion.

National GP survey results published in January 2015 indicated that the practice was best in the following areas:

- 95% of respondents say the last GP they saw or spoke to was good at giving them enough time. Local (CCG) average: 85% National average: 87%
- 87% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. Local (CCG) average: 77% National average: 82%
- 93% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. Local (CCG) average: 83% National average: 86%

National GP survey results published in January 2015 indicated that the practice could improve in the following areas:

- 37% of respondents usually wait 15 minutes or less after their appointment time to be seen. Local (CCG) average: 56% National average: 65%
- 57% of respondents find it easy to get through to this surgery by phone. Local (CCG) average: 75% National average: 74%
- 40% of respondents with a preferred GP usually get to see or speak to that GP. Local (CCG) average: 57% National average: 60%

There were 452 surveys sent out, 101 returned giving a completion rate of 22%.

Wellfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector, two specialist advisers, a GP and a practice manager, and an expert by experience who is a member of the public trained by the CQC.

Background to Wellfield Medical Centre

The Wellfield Medical Centre has about 9,700 patients registered and is part of North Manchester Clinical Commissioning Group (CCG). The population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There are a lower proportion of patients above 65 years of age (7.5%) than the practice average across England (16.7%).

There are four partner GPs and two salaried GPs who are supported by three practice nurses. There is also a practice manager, office supervisor, reception team, medical secretaries, computer team and a housekeeping team.

The practice delivers commissioned services under the General Medical Services (GMS) contract.

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are from 8.35am to 6pm daily.

Patients can book appointments in person or via the phone and online. Emergency appointments are available each day. Bury and Rochdale Doctors (BARDOC) provide urgent out of hours medical care when the practice is closed.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and North Manchester Clinical Commissioning Group (CCG) information showed the practice rated as an achieving practice.

Why we carried out this inspection

We inspected this service as part of our new 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

Detailed findings

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

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

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also reviewed further information on the day of the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 23 June 2015.

During our visit we spoke with a range of staff, including the GPs, practice nurses, practice manager and a range of administrative staff and spoke with eight patients who used the service. We also reviewed information from the completed CQC comment cards. We observed how people were being cared for and talked with carers and/or family members.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included 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 minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and showed evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these.

We saw that incidents and all details of investigations were recorded. All learning points were documented and included discussions with the patient at the centre of the incident, reviews of medication, and sharing of information internally with clinical and non-clinical staff when appropriate, and externally with the North Manchester Clinical Commissioning Group (CCG).

We looked at the systems to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to clinical and non-clinical practice staff when necessary. These are alerts issued to healthcare staff on patient safety issues that require urgent attention and/or action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. Two of the GPs in the practice had been trained to level 3 safeguarding vulnerable adults and children, and all other clinical staff and the practice manager up to level 2. Remaining staff were trained to level 1 safeguarding. We asked members of medical, nursing and administrative staff about their training. Staff were aware who the lead was and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew what to do if they encountered safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for local authority safeguarding personnel were accessible to all staff.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example if a child was subject to a child protection plan. The practice recorded the identity of the adult attending with children, and children on protection plans had a clear warning flag in their patient record.

There was a chaperone policy. Staff had been trained to be a chaperone (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for maintenance of the cold chain and action to take in the event of a potential failure. We also saw that the temperature of the fridges, used specifically for the storage of medicines and vaccines, were regularly checked and recorded. Cold chain protocols were strictly followed. We saw written records of these and this was confirmed by staff. The "cold chain" is the process of keeping medicines within a safe temperature range.

The practice nursing team oversees the processes in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Good

Are services safe?

Vaccines were administered by the practice nurse using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nursing team had received appropriate training and regular updates to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Any medicines alerts that were received were reviewed and then disseminated to all clinical staff when necessary.

The doctor's bag was securely stored when not in use. We checked the contents of the bag and all the drugs were in date. These were regularly checked by the nursing staff and we saw documentary evidence of these checks. Identical bags were provided for all doctors in practice who do home visits.

Cleanliness and infection control

There were systems were in place that ensured the practice was regularly cleaned. A member of the practice nursing team took the lead for infection control within the practice supported by the practice manager. We found the practice to be clean at the time of our inspection and there was a dedicated housekeeping team that undertook this task. We also saw cleaning checklists were in place and regularly completed. A system was in place to manage infection prevention and control. We saw that recent audits relating to infection control and hand washing had been completed to ensure actions taken to prevent the spread of potential infections were maintained.

We also saw that practice staff were provided with equipment such as disposable gloves and aprons. This was to protect them from exposure to potential infections whilst examining or providing treatment for patients. These items were readily available to staff in the consulting and treatment rooms.

We looked at the consulting and treatment rooms and found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance with most equipment for single use only. We looked at medical equipment and found that it was all within the manufacturers' recommended use by date.

The practice was registered to carry out minor surgical procedures such as joint injections. We looked at the treatment room used for carrying out minor surgical procedures. This room was also clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place and medical instruments used for minor surgical procedures were disposed of after single use. Unused medical instruments and dressings were stored in sealed packs. We looked at these and found all to be within the expiry date on the packs.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Sharps boxes were provided for use and were positioned out of the reach of small children. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella, a germ found in the environment which can contaminate water systems in buildings. We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. Legionella testing had taken place.

Equipment

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

We also saw that fire and intruder alarms were regularly tested, checked and serviced. There were also checks of fire extinguishers

Good

Are services safe?

Staffing and recruitment

There was a practice recruitment policy in place that included the principles of The Equality Act 2010, Employment Rights Act 1996, Human Rights Act 1998, General Medical Services Contracts Regulations 2004 and Personal Medical Services Agreements Regulations 2004. This policy set out the standards it followed when recruiting clinical and non-clinical staff.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) if necessary. The practice had a risk assessment in place to determine which staff required DBS checks. This included a scoring system that determined whether a staff member, for example, would be unsupervised with children or vulnerable adults or had unsupervised access to the building.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for members of the administrative staff team to cover each other's annual leave. There was a system in place to use locum staff to support the practice when needed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use.

Some of the staff at the practice had been employed for many years and knew the patients well. Staff we spoke to told us they were able to identify if patients were unwell or in need of additional support, they told us that this meant that they could make arrangements for the patient to be helped accordingly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator, used to attempt to restart a person's heart in an emergency. Emergency oxygen was also available if needed. Staff that would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experienced a cardiac arrest. All staff asked knew the location of this equipment and records we saw confirmed these were 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.

The practice followed its own major incident protocol in the event of a serious emergency that could affect safe patient care and treatment This plan is designed to ensure that the business can continue to operate (as far as possible) in the event of any unexpected disaster, incident or major occurrence which has the potential to de-stabilise the business and severely impact on the short, medium to long term running of the business. Risks identified included loss of computer system, loss of GP availability and loss of power. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. This assessment was due for a further review. Records showed that staff practised regular fire drills. An unplanned alarm went off during the inspection and the building was evacuated. We observed staff to deal with the situation in a professional and sensitive way that ensured that patients and staff were safe.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nursing team we spoke with could clearly describe 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. We found from our discussions with the GPs and nursing staff that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

We saw that the GPs took the lead in all specialist clinical areas such as minor surgery, child health, family planning and osteoporosis. We saw evidence that all partner and salaried GPs were skilled in specialist areas which helped them ensure best practice guidance was always being followed. The practice nursing team supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed.

Discrimination was avoided when making care and treatment decisions. Interviews with the GPs and other staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice demonstrated to us that clinical audits had been undertaken. We saw examples of completed audits including around cervical screening, cytology, epilepsy and hypertension. We observed a presentation on chronic kidney disease which was very comprehensive and a learning tool for the trainee doctors. All of this demonstrated an effective response to any possible risk to patient safety. We also saw there was a completed audit of the management of Atrial Fibrillation, which is an area where there is scope for improvement in stroke prevention. The practice had an audit timetable in place up to the end of March 2016.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had achieved and implemented the gold standards framework for end of life care. Quarterly Palliative care meetings were held with a multidisciplinary team consisting of the GPs, district nurses and specialist palliative care nurses to review patient on the palliative care register.

Effective staffing

We reviewed staff files and training records and had discussions with all staff. This demonstrated that all staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. We saw evidence that new staff undertook orientation and induction training and the staff we spoke

Good

Are services effective?

(for example, treatment is effective)

with confirmed this. Induction included an introduction to the practice, terms and conditions, equal opportunities, employee development including training and appraisal and health and safety.

We saw that appraisals had been undertaken and that there were plans in place for all staff to have an appraisal and review this year. The appraisal included discussions on an individual's strengths, skills and training. There were also discussions on what had gone well, what needed improvement and supported by their personal development needs and future plans. Staff we spoke with said they were being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. All the GPs had an annual appraisal. Those GPs who had not yet been revalidated have up to date personal portfolios that will support this process.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x ray results, and letters from the local hospital including discharge summaries, and out of hours services both electronically and by post. The practice had systems in place that defined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GPs who saw these documents and results were responsible for taking any action that may be required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held meetings to discuss the needs of complex patients, for example those with end of life care needs, children on the "at risk" register and vulnerable adults. These meetings were attended by district nurses, social workers and palliative care nurses when necessary. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the meeting with other professionals as a means of sharing important information.

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals centrally within the CCG. They then process the request through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in meeting their requirements. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All GPs had undertaken mental capacity act training.

The 2015 national GP patient survey indicated 93% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 87% said the last GP they saw or spoke to was good at involving them in decision making and 95% had confidence and trust in the last GP they saw or spoke to.

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who

Good

Are services effective?

(for example, treatment is effective)

were registered as carers and any other information relating to consent was put onto the system and alerts were set up to notify clinicians. We also saw that written consent was obtained from patients who required a minor surgery procedure following a discussion with them regarding the risks.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice demonstrated a commitment that ensured their patients had information about a healthy lifestyle. This included providing information about services to support them in doing this. There was a range of information available for patients displayed in the waiting area and on notice boards in the reception areas. This included information on meningitis, chaperones, advocacy and a variety of drop in clinics. They also provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice worked proactively to promote health and identify those who require extra support, for example those with long term conditions. There was evidence of appropriate literature and of good outcomes for these areas as demonstrated in the QOF data.

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. Staff we spoke with were knowledgeable about other services and how to access them. The practice nursing team offered appointments for cervical smears, smoking cessation, weight management, child health surveillance and well-baby clinics.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. If a patient required any vaccinations relating to foreign travel they made an appointment with the practice nurse to discuss the travel arrangements. This included which countries and areas within countries that the patient was visiting to determine what vaccinations were required. The practice was registered as a yellow fever centre, therefore providing a service for patients that were not registered with this practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However there were comments about the length of time it took for the phone to be answered however we say evidence of work in progress to address this issue.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We noted that the waiting area was located away from the reception desk which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. There was also a privacy room available in the reception area that could be used to facilitate a private conversation with a patient if required.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with their line manager. These would then be investigated and any learning identified would be shared with staff.

We looked at the results of the 2015 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 90% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 95% of respondents said the last nurse they saw or spoke to was good at listening to them.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

The practice used a translation service when needed and they arranged for an interpreter to attend the surgery if necessary. They also used a telephone translation service to support people who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the information available for carers to ensure they understood the various avenues of support available to them.

We saw that there was a system for notifying staff about recent patient deaths. Staff told us that this was helpful when speaking to relatives and others who knew the person who had died. We were told that families who had suffered bereavement were called by the GP to offer support and condolences.

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

NHS England and the local Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We saw the practice carried out regular checks on how it was responding to patients' medical needs. This activity analysis was shared with North Manchester CCG and formed a part of the Quality and Outcomes Framework monitoring (QOF). It also assisted the practice to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews.

Each patient contact with a clinician was recorded in the patient's record, including consultations, visits and telephone advice. The practice had a system for transferring and acting on information about patients seen by other doctors and the out of hour's service. There was a reliable system to ensure that messages and requests for visits were recorded and that the GP or team member received and acted upon them. The practice had a system in place for dealing with any hospital report or investigation results which identified a responsible health professional and ensured that any necessary action was taken. There was a system to ensure the relevant team members were informed about patients nearing the end of their life. There was also a system to alert the out of hour's service if somebody was nearing the end of their life at home.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to individual needs and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. People in vulnerable circumstances were able to register with the practice.

The premises and services had been adapted to meet the needs of people with disabilities. There was a suitable entrance at the front of the building for wheelchair use access, and also disabled toilet facilities available. There was a hearing loop available. This is an assistive listening technology for individuals with reduced ranges of hearing.

We saw that the waiting area was large enough to accommodate patients with wheelchairs, mobility scooters and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was a lift that facilitated access to the upper floor.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The national GP survey results published in January 2015 showed that only 57% of patients said it was easy to get through to the practice to make an appointment. However 85% of patients said they found the receptionist helpful once they were able to speak with them and this was average for the local CCG. Patients we spoke with told us that they did not have difficulties in contacting the practice to book a routine appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

We arranged for a Care Quality Commission (CQC) comments box to be placed in the waiting area of the practice several days before our visit and seven patients chose to comment. All of the comment cards completed were very complimentary about the service provided apart from the length of time they had to wait to be seen. This was because the practice had a policy for seeing all patients on the day if that was required.

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. If that person was unavailable to handle that complaint in a timely manner then the complainant would receive a holding letter stating when the complaint would be dealt with.

Patients we spoke with knew how to raise concerns or make a complaint. Information on how to complain was on the practice website. We looked at complaints received and found they had been satisfactorily handled and dealt with in a timely manner.

Patients were informed about the right to complain further and how to do so, including providing information about relevant external complaints procedures. Patients we spoke with said they would be able to talk to the staff if they were unhappy about any aspect of their treatment. Staff we spoke with told us that not all verbal complaints were recorded if they could be resolved at the time.

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 statement of purpose which was to provide people registered with the practice with a wide range of NHS primary medical services under the general medical services (GMS) contract. The practice aimed to ensure they provided high quality, safe and effective services in an appropriate environment, supported by suitably qualified and trained staff. They also aimed to provide available healthcare for the patient population and to create a partnership between patient and health professional which ensures mutual respect, holistic care and continuous learning and training. They also ensured that all patients were treated fairly and without discrimination, and that patients, their families and carers were involved in decisions regarding their treatment and care.

The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

The practice website and patient participation group (PPG) demonstrated that the practice was interested in obtaining the views of their patients and carers and these views were used to consider how the service could be improved. The staff were dedicated to providing a service with patient's needs at the heart of everything they did.

GPs attended locality and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly.

The practice was proud that they had all "Lloyd George" patient records electronically stored on the computer system. Information technology has been embraced by the practice and the GPs took a tablet computer (IPad) with them for home visits. They also used voice recognition for dictation and could sign letters digitally in accordance with information protocols.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice.

There was a clear leadership structure with named members of staff in lead roles such as a GP was the lead for safeguarding children and vulnerable adults. There was also a lead for infection control. The GPs took the lead for all clinical matters. The practice nursing team led for chronic disease management supported by the GPs. We spoke with 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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or from safety alerts. We looked at several clinical audits and found they were well documented and demonstrated a full audit cycle.

Leadership, openness and transparency

We saw from minutes that practice meetings were held regularly but would be convened at any time if circumstances demanded. There were daily management meetings with the registered manager, a GP partner, and the practice manager. There were also clinical practice meetings and meetings specific for the administrative and support staff. These were supported by other meetings such as the external practice manager and practice nurse forums. One partner GP represented the practice at clinical commissioning group meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at all these meetings. The minutes of meetings were disseminated to staff. We noted that risk management and quality improvement were standing agenda items for practice meetings.

We reviewed a number of policies which were in place to support staff. We saw that there were staff employment policies in place such as dignity at work, equal opportunities and data protection. We were shown the information that was available to all staff, which included

Are services well-led?

Good

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

sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. Staff we spoke with were aware of the whistleblowing policy and what to do if they were concerned about any matters.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

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

The practice and all staff recognised the importance of obtaining and acting upon the views of patients and those close to them, including carers. A proactive approach was taken to seek a range of feedback.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice. The practice also responded to any comments on the NHS Choices website in a timely manner.

The practice had a patient participation group (PPG). This was an online group that discussed a variety of clinical and administrative points including information on the friends and family test and appointments. These were supported by action points and these were reviewed at subsequent meetings to ensure that action had been taken. For example the feedback received from the PPG was pivotal in the decision making process for the installation of a telephone call monitoring system in reception.

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

Management lead through learning and improvement

Staff told us that the practice supported them to develop through training and mentoring. We saw that all staff had annual appraisals. Staff told us that the practice was very supportive of training and provided them with eLearning. There was also some face to face learning. Training included basic life support, mental capacity and consent, equality and diversity, chaperoning, infection control, and safeguarding children and vulnerable adults. There was a training matrix and a plan for staff to complete essential training throughout the year.

The practice had completed reviews of significant events and other incidents and shared with staff team meetings to ensure the practice improved outcomes for patients.

The practice is a GP training practice. Information about this was displayed for patients in the reception area. As a training practice they worked closely with the University of Manchester and provided educational facilities for all levels of medical students throughout the scholastic year. These students were supervised by the GP Partners.