# Albion Medical Practice

## Quality Report

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

The practice were registered to carry out activities in relation to diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury. Staff included five partners, trainee GPs, nurses, health practitioners, administrators and receptionists. We spoke with 13 patients, four by telephone before the inspection and also talked to 11 members of staff.

Patients told us they were very happy with the care and treatment they received and they felt safe. There were robust systems in place to help ensure patient safety through learning from incidents and the safe management of medicines. Staff were able to describe how they would deal with any cases of abuse or emergency and were trained on how to keep people safe.

The service is effective in obtaining patients' views regularly and these are used to make improvements to the service provided. Complaints and adverse incidents were recorded and dealt with appropriately.

The provider is responsive and the practice is well led. Access to the service is offered in varying ways and to people in different population groups. There are clinics to help people with long term conditions, mental illness and learning disabilities. However there is no system in place to proactively reach people in vulnerable circumstances who find it difficult to access primary care services.

Although there is a system in place to check and regulate the temperature of the fridges where medication is kept, we found that this system is not effective. When we checked the fridge temperatures we found they had been continually recorded at heights that would render medication unsafe for use if the temperature had been as recorded. This had not been reported, escalated or dealt with and had occurred over a substantial period of time.

There is no evidence that a cold chain policy is in place. This policy is required to ensure that medicines are stored at the correct temperatures and that staff understand what to do in the event of a breakdown in systems.

This meant the practice were in breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines Management, because patients were not protected against the risks associated with medicines.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

We found that systems were in place to address incidents, deal with complaints and protect adults and children who used the service. Patients we spoke with told us they felt safe. We saw recruitment systems which ensured most checks were made on staff before they were employed which clarified they were suitable to work with vulnerable people.

There was no cold chain policy for the storage of medicine and the procedure was not followed for the recording of fridge temperatures. The recorded temperature readings were too high and no action was taken to report or address this. This could have compromised patient safety which we fed back to one of the doctors and the practice manager at the inspection.

**Are services effective?**

We found the practice to be effective. Care and treatment was delivered in line with current best practice. and the practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience and we saw robust processes in place to ensure staff were developed in their role.

**Are services caring?**

The practice was caring. We spoke with 13 patients who were all extremely complimentary about all the staff and the treatment received. In particular we were told that patients felt more than just well cared for and that staff were considerate, friendly, genuinely concerned and attentive to their needs. We observed very positive interaction between staff and patients and patient experience surveys showed a high degree of satisfaction with the service provided.

**Are services responsive to people's needs?**

The practice was responsive. Appointments were easily accessible and there was an open culture within the organisation and a clear complaints policy. Patient suggestions for improving the service were acted upon and the provider participated actively in discussions with commissioners about how the service could be improved. Patients who had made comments about the service told

# Summary of findings

us that they had seen changes made. There were two television screens in the waiting room and one showed local health information and information on lifestyle management such as diets and alcohol.

**Are services well-led?**

The practice was well led. There were clear lines of management and the vision and purpose of the service was shared by all staff. Governance structures were robust and there was a system in place for managing risks.

However we found that improvements could be made to policies and procedures to ensure that best practice, dissemination of information and learning from events remained consistent across all members of staff.

# Summary of findings

## The six population groups and what we found

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

**People with long-term conditions**

We saw that patients with long term conditions were supported by a system of collaborative care that involved management, follow up and referral to other services, such as secondary or acute care, when required. There was information displayed in the waiting areas and on the practice website explaining different long term conditions in detail and signposting access to other services.

**Mothers, babies, children and young people**

The practice offered services to mothers and their children in the form of family planning and child health surveillance clinics. There were also clinics led by the practice nurses and vaccination sessions each month.

**The working-age population and those recently retired**

The practice provided screening programmes, vaccination clinics and various other services. They worked with other health and social care professionals and shared information to ensure that patients received an all round and holistic service relating to their needs.

**People in vulnerable circumstances who may have poor access to primary care**

The practice received information from accident and emergency departments at neighbouring hospitals and the information provided details of patients who were registered at the practice some who were people with poor access to primary care. This prompted the practice to proactively try to make contact with those people. However, there were no formal systems in place to reach communities such as gypsies, travellers and sex workers.

**People experiencing poor mental health**

Patients with mental health problems were able to access a doctor when required in a timely manner and there was information about depression and mental illnesses available on the practice website and in the patient waiting areas. The practice encouraged its patients to complete a depression questionnaire which was available on-line and could be transferred straight to the GP before the patient's next visit. When patients completed this, the reviewing GP always had up to date information about their current mental state.

# Summary of findings

## What people who use the service say

Patients and their relatives and carers told us that they felt safe, well cared for and very happy with the treatment provided. They said that all staff at the practice treated them with dignity, respect and understanding. All the patients spoken with said their privacy was maintained, they were involved in decision making and were always asked for their consent or permission before any invasive treatment or examinations took place. No one spoken with had experienced difficulty accessing the service. There were robust systems to make sure that people whose first language was not English were understood and that they received the same service as others.

Patients said they were actively encouraged to comment on the service provided. We reviewed compliments and complaints for the service and saw that people were listened to and action taken to resolve any issues. Patients were particularly complimentary about the staff and the friendly attitude of everyone who provided a service at the practice.

Patient surveys undertaken by the practice showed that overall people were very happy with the service. However comments suggested that some people found it difficult to make routine appointments outside of work hours or less than two weeks in advance. Patients said there was never any issue if the appointment was urgent. The practice were making changes to the way appointments were booked in the hope of improving access for everyone.

## Areas for improvement

**Action the service MUST take to improve**

Although there was a system in place to check and regulate the temperature of the fridges where medicines were kept, we found that this system was not effective. When we checked the fridge temperatures we found they had been continually recorded at heights that would render medicines unsafe for use if the temperature had been as recorded. This had not been reported, escalated or dealt with and had occurred over a substantial period of time.

There was no evidence that a cold chain policy was in place. This policy is required to ensure that medicines are stored at the correct temperatures and that staff understand what to do in the event of a breakdown in systems.

This meant the practice were in breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines Management, because patients were not protected against the risks associated with medicines.

**Action the service COULD take to improve**

In the case of three GPs their notes were typed up by administration staff and not checked by the GP following a home visit, sometimes until the patient was next seen. There was a risk that errors in medicine or treatment could be made if the information was incorrectly typed. Action to rectify this was taken immediately following the inspection.

Some staff did not have sufficient knowledge about the Mental Capacity Act 2005.

Although serious adverse events were recorded and shared there was no confirmation that actions were completed with dates for review to close the process.

Prescription pads were not kept safely locked away from the risk of theft and abuse.

## Good practice

The practice had an online service which allowed people to book appointments, request repeat prescriptions and email the practice with questions about their medicine.

Text messaging reminders were sent to remind people of future booked appointments. This had reduced the level of appointments which were not attended.

# Albion Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead inspector, a GP Specialist and an expert by experience.

Experts who take part in inspections, for example, experts by experience, are not independent individuals who accompany an inspection team; they are a part of the inspection team and are granted the same authority to enter registered persons' premises as the CQC inspectors.

## Background to Albion Medical Practice

Albion Medical Practice was located near Ashton-Under-Lyne town centre and had a patient population of 9,803 people who lived in the local area. The building had three levels, lower of which was used by the nursing staff. Wheelchair access was available through a back lower level entrance. The top level was utilised by the administration team and the practice manager. There were five GP partners and a GP trainee as well as an advanced nurse practitioner, practice nurses and an assistant practitioner who were all able to provide a service. Health visitors and district nurses were attached to the practice and were contactable at a neighbouring clinic. A group of midwives attended the practice on a rotational basis and appointments were available through the normal channels. An urgent surgery was available between Monday and Friday and patients also had access to Ashton Walk-in Centre and the Out of Hours Service (Go-to-Doc) during evenings and weekends.

## Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

## How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 14 May 2014. During our visit we spoke with the GPs, nurses, practice manager, administration and

# Detailed findings

reception staff. We also spoke with patients. We observed patients in the waiting areas, and saw how they were treated by staff. We reviewed information such as surveys, compliments and complaints, where people had expressed their views.

# Are services safe?

## Summary of findings

We found that systems were in place to address incidents, deal with complaints and protect adults and children who used the service. Patients we spoke with told us they felt safe. We saw recruitment systems which ensured most checks were made on staff before they were employed which clarified they were suitable to work with vulnerable people.

There was no cold chain policy for the storage of medicine and the procedure was not followed for the recording of fridge temperatures. The recorded temperature readings were too high and no action was taken to report or address this. This could have compromised patient safety which we fed back to one of the doctors and the practice manager at the inspection.

## Our findings

### Safe patient care

We saw mechanisms in place to report and record safety incidents and we spoke with staff who were able to describe what they would do in the event of any issue or emergency. There was evidence that information about adverse events and complaints from patients was shared through discussion with staff at weekly meetings and learning was continuous. Meetings from these minutes were disseminated to staff through a buddy system or via email. There was extensive support and training for staff which enabled them to progress within their roles. The practice did not replace "like for like" if staff left and instead discussed areas where skills were missing and replaced staff in this way or trained staff into those roles. This was to ensure that staff always had the skills required to meet the needs of the practice and the patients who used it.

### Learning from incidents

We saw that serious adverse events were recorded and that action was taken when required. The events were discussed at practice meetings and shared with staff. If necessary training was updated and there were changes made to policy and procedure if that was necessary. We reviewed the serious adverse events that had been recorded and saw that action had been taken to change practice when required. However there was nothing to show what went well, what went wrong, other agencies involved, who was responsible for carrying out actions or confirmation that actions were completed and reviewed. There was no formal closure for each event.

There were systems in place to help protect people from the risks associated with the management of medicines and infection control. However we found that these were not always effective and improvements were required.

Staff met often, discussed issues and mostly shared learning. We found that improvements were required to ensure that all staff received and understood information that was disseminated and patient safety was not compromised because communication had broken down. For example one member of staff we spoke with had not been aware of a prescription related incident.

### Safeguarding

All staff spoken with were able to describe the different forms of abuse and knew what to do in the event of any

concerns. Staff had a direct link with the Tameside safeguarding lead and contact numbers were on view in reception and in the clinical rooms. Two of the GPs took the lead for safeguarding within the practice but had only undergone level 2 training. They had made arrangements to undertake level 3 training in the near future. One of the GPs had recently attended the local Tameside safeguarding meeting and this meant the practice were aware of current safeguarding issues within the area. There was a safeguarding policy which all staff had seen and knew how to access. The policy had not been dated and there was no review date.

### Monitoring safety and responding to risk

There were systems in place to identify and monitor risks to patients. For example staff levels and skill mix were maintained throughout the day to ensure that patient needs were met. Most 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, agitated or distressed and could take them to a private room if necessary whilst they waited for assistance.

Staff knew what to do in emergency situations and were trained on how to identify and respond to emergency situations such as sudden illness or fire. Emergency equipment and emergency drugs were available and up to date. However we found that staff knowledge about the whereabouts of the emergency equipment was not consistent. This would have an adverse effect on patient safety in an emergency situation.

### Medicines management

Although there was a system in place to check and regulate the temperature of the fridges where medicine was kept, we found that this system was not effective. When we checked the fridge temperatures we found they had been continually recorded at heights that would render medicine unsafe for use if the temperature had been as recorded. This had not been reported, escalated or dealt with and had occurred over a substantial period of time.

There was no evidence that a cold chain policy was in place. This policy is required to ensure that medicines are stored at the correct temperatures and that staff understand what to do in the event of a breakdown in systems.

There was a process for ensuring medicines within GP's bags for home visits was safe for use. Each doctor collected the drug boxes from the practice manager's room to take with them. Drugs that were required by the doctors had been reviewed recently and rationalised. They did not carry opiates. The expiry dates were monitored by the associate practitioner and the practice manager to ensure they were kept in date. We looked at the doctors "home visit" bags and checked the medicines that were in it. These drugs were all within their "use by" date and were appropriate for dealing with emergencies that the GP may encounter.

Prescription pads were not kept safely locked away from the risk of theft and abuse.

### Cleanliness and infection control

We looked at all areas of the practice including clinic rooms and doctors surgeries. The building was clean and tidy and the waiting room was uncluttered. We reviewed the infection control policy and staff spoken with told us they knew how to access this policy. The practice used a cleaning agency and cleaners attended on a daily basis. The assistant nurse practitioner was the infection control lead and was aware of requirements such as sharps disposal and what to do in the event of a needle stick injury. Other clinical staff spoken with were also aware of these requirements. Only single use equipment was used which was disposed of through clinical waste and there was no need for any decontamination process to take place. We saw that contracts for disposal were in place and up to date.

### Staffing and recruitment

The majority staff had been employed by the practice for more than five years. We spoke to the most recently employed members of staff who had been there between 18 months and two years. They told us they had been asked to provide two references and had shown their passport and/or driving licence to prove their identities. We reviewed seven staff files and saw no recorded evidence on those files that the necessary checks such as photographic identification had been sought. There was an up to date recruitment policy in place which stated that only clinical staff required disclosure and barring service checks. However there was no evidence that risk assessments were undertaken to support a reason why disclosure barring information had not been required for administration staff.

# Are services safe?

### Dealing with Emergencies

The administration staff had undergone training in Cardio-Pulmonary Resuscitation (CPR). One member of staff was recorded on the training matrix as having been trained in “crash”. Crash is a situation where a person becomes unexpectedly, severely ill requiring urgent intervention. According to the staff training matrix all staff had been trained on what to do in the event of fire. Staff asked were able to describe the process and we saw that the fire alarm was checked on a weekly basis. We saw that a fire drill evacuation had taken place when patients were present and this was scheduled to be done again. There was a business continuity plan which covered all areas such as staff, equipment and access to alternative premises in the event of any emergency which could disrupt the service.

### Equipment

We saw evidence that fire equipment checks such as smoke alarms and extinguishers, were up to date, and maintenance contracts were in place. A member of nursing staff showed us that oxygen was available on the nursing floor but it was not clear who was responsible for checking that the oxygen and other emergency equipment was effective.

We reviewed the maintenance contracts with the practice manager and saw that portable appliance testing was undertaken to ensure that small electrical items were safe to use.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

We found the practice to be effective. Care and treatment was delivered in line with current best practice. and the practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience and we saw robust processes in place to ensure staff were developed in their role.

## Our findings

### Promoting best practice

Patients we spoke with said that they received care which was appropriate to their needs. Some patients with long term conditions and multiple ailments told us they saw different staff who were all appropriately skilled to deal with their conditions. There was a weekly meeting between the GPs and the nursing staff where clinical discussions took place and individual cases were discussed to ensure that all treatment options were covered. The practice aimed to follow best practice such as The National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

The practice kept up to date with changes in medicines through NHS mail and a mobile phone application was used to ensure the most up to date and effective antibiotic was prescribed in relation to any particular infection. One of the GPs also attended local area meetings to keep up to date with current legislation.

The GPs referred to competency guidance when assessing young people's ability to understand or consent to treatment to ensure that their rights and wishes were considered and decisions were made which kept them safe.

There was no mention of the Mental Health Act 2005 in the practice consent policy and no evidence that this was referred to when assessing a patient's capacity to make informed decisions.

### Management, monitoring and improving outcomes for people

The practice manager and other staff we spoke to were able to evidence that clinical audits were undertaken in order to improve outcomes for people. We were shown minutes from meetings which had taken place to support decisions about clinical effectiveness. Information from these meetings was disseminated to staff and practice was changed when required.

We saw evaluations of medicines for people with heart problems or asthma and we saw where treatment had been changed if required following these evaluations so that the best outcome for the patients could be achieved.

# Are services effective?

## (for example, treatment is effective)

We saw where changes in treatment were offered, and sometimes refused, the patient was given information by the practice about the benefits or otherwise and were therefore enabled to make an informed decision.

The practice reviewed emergency admissions to hospital to ascertain whether anything could be done differently to prevent admissions or reduce the patient's length of stay in hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

Clinical supervision meetings were carried out regularly between the advanced nurse practitioner and junior doctors and their supervising mentors. Most staff with one exception said they had regular formal clinical supervision and were happy with the mentoring process. All staff said they could speak to any one of their peers or superiors if they were concerned or unsure about any element of clinical practice.

### Staffing

All the staff at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. The partners told us "we grow our own here".

We saw there was a robust induction process which consisted of staff shadowing other staff and undertaking competency tests to ensure they were proficient before continuing on their own. One to one supervision meetings were undertaken regularly with all staff and we saw evidence to support those meetings. Doctors were revalidated, appraisals were carried out annually on all staff and staff conducted 360 degree evaluations of each other, openly sharing areas of good practice and opportunities for improvement. All staff spoken with said they found this to be a positive experience and were open and honest with each other about ways their practice could be improved. One member of the administration staff explained how she had been given feedback and changed her practice for the better. This in turn improved the experience for the patients.

All patients we spoke with were complimentary about the staff and we observed staff who appeared extremely competent, comfortable and knowledgeable about the role they undertook.

### Working with other services

All the staff at the practice worked closely together to provide an effective service for its patients. They also worked collaboratively with other services to ensure all round care for patients was achieved. Information was shared appropriately and audits were undertaken to establish if the patient's treatment could be managed in primary care or required a multi disciplinary team approach. Health Visitors and District Nurses were available at a neighbouring clinic and midwives attended the practice on a rotational basis. We spoke with three patients who told us their doctor had liaised with other services on their behalf and had signposted them in relation to bereavement, cancer and depression to ensure they received the support they required to manage their difficulties.

### Health, promotion and prevention

The assistant practitioner at the practice held clinics to promote healthy living and provided advice on smoking cessation, diet and alcohol intake. There were also clinics specific to Child Health Surveillance Services and Young People's Services.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle.

# Are services caring?

## Summary of findings

The practice was caring. We spoke with 13 patients who were all extremely complimentary about all the staff and the treatment received. In particular we were told that patients felt more than just well cared for and that staff were considerate, friendly, genuinely concerned and attentive to their needs. We observed positive interaction between staff and patients and patient experience surveys showed a high degree of satisfaction with the service provided.

## Our findings

### Respect, dignity, compassion and empathy

The provider's induction and training programmes emphasised the need for a patient centred approach to care. Patients we spoke with told us they felt more than just well cared for and that staff were considerate, friendly, genuinely concerned and attentive to their needs. We saw that patient experience surveys conducted by the provider showed a high degree of satisfaction with the service provided and the attitude of staff towards patients. We observed very positive interaction between staff and a patient who appeared to be having trouble with the booking system and saw that their issue was resolved efficiently and respectfully. There was a genuine friendly connection between the reception staff and the patients of all ages.

At busy times the area by the door and reception became overcrowded but we saw that there was a separate reception area for patients collecting repeat prescritpions which meant that appointments could be dealt with independently. On one occasion we witnessed the reception staff direct a patient from the appointment reception to the prescription reception to maintain privacy. There a private room for people to use if they did not want their conversation to be overheard or if there was a risk of the spread of infection. Despite the restrictions on space at the entrance the flow of patients and staff through reception appeared to be well-managed.

We spoke with one person who had been bereaved and they said they had received considerable emotional support from the clinicians and administration staff at the practice. They said they were signposted to appropriate services for alternative support and that their needs were met. They said "the doctor rang me some time later, just to see how I was getting on, whether I was okay and to see if I needed anything. I found that very comforting and reassuring".

### Involvement in decisions and consent

The service promoted patients' involvement in the planning and decision making about their treatment. There was an ethos of "self responsibility" and people were encouraged and supported to help themselves. The patients spoken with told us they were always asked for their consent before any procedure or treatment was undertaken. We were also told that there was ample

# Are services caring?

opportunity to discuss any health concerns and two patients explained how their families or carers, at their request, had been included in discussions about their treatment.

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

We looked at the consent policy and talked to clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements. There was no mention of the Mental Capacity Act, best interests or diminished mental capacity. Administration staff spoken with did not have trained knowledge of the Mental Capacity Act but would escalate any concerns if they were in doubt about a patient's mental health or capacity to make a decision.

Staff knew where to access the policy and understood what was meant by "consent". There were clear processes for chaperoning patients and administration staff were trained to undertake this role when required. Patients and staff were aware of the chaperone arrangements and they understood how to escalate any areas of concern.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The practice was responsive. Appointments were easily accessible and there was an open culture within the organisation and a clear complaints policy. Patient suggestions for improving the service were acted upon and the provider participated actively in discussions with commissioners about how the service could be improved. Patients who had made comments about the service told us that they had seen changes made. There were two television screens in the waiting room and one showed local health information and information on lifestyle management such as diets and alcohol.

## Our findings

### Responding to and meeting people's needs

The practice were aware of the different needs of the population it served and aimed to design its service accordingly. The statement of purpose said that the practice "endeavoured to monitor the service provided and ensure that it met current standards of excellence". Staff at the practice met regularly with the local commissioning group to discuss any barriers which would affect the service provided. Recently a petition had been presented to the local council on behalf of the patients at the practice because of a lack of parking for disabled patients. We were told that the practice manager met regularly with other practice managers in the area and discussed ways to improve services for people by sharing local information. There was an annual face to face meeting with the Patient Participation Group (PPG) where improvements to the service were put forward, considered and changes made if possible and appropriate. Patients were able to access the service by telephone for things such as test and x-ray results or repeat prescriptions. Audits were undertaken to identify the timeliness of referrals to other services and "Choose and Book" was used to enable patient preference when referring to other hospital services.

There were clinics to monitor patient chronic disease management such as diabetes, asthma, COPD and hypertension.

Patients we spoke with told us that the doctors knew them very well and that medical histories were taken and reviewed on a regular basis to make sure no changes had occurred since they last visited the practice. One new patient spoken with confirmed that the doctor had taken a full medical history and had asked questions about their social and cultural background. They also said that their medical records had been transferred and updated.

### Access to the service

Staff told and showed us how the appointment system was easy to use and supported access and choice. Most patients said they did not have problems accessing the service and that an emergency appointment was always available if required. However, some people expressed frustration at the inability to book more than two weeks in advance for routine appointments which they knew would be required in three months' time.

# Are services responsive to people's needs?

## (for example, to feedback?)

We were shown that a request had been made by the PPG to introduce a "Doctor First Service". Doctor first is a demand led system that allows practices to effectively manage patient demand by clinicians talking to all patients prior to an appointment. It does not remove the need for an appointment if the patient still wished to see the doctor. The practice were not currently able to provide this service so in the meantime they had introduced a telephone triage system for home visit requests.

### Concerns and complaints

There was a robust system in place to advertise, record and respond to complaints and concerns from patients of the practice. There was clear information in the reception area and on the practice website about how to make a complaint and how that complaint could be escalated to the Ombudsman, if the patient was dissatisfied with the response. None of the patients we spoke with had needed to make a complaint at any time. One said they had had slight concerns about a situation, had reported it and had received a satisfactory response.

We were shown the complaints log for the practice and saw there had been 16 formal complaints during the year 2013/2014. Seven of those had been in relation to clinical practice. We saw that one complaint had been escalated and was being dealt with by the Parliamentary and Health Service Ombudsman. We saw that responses were sent to the patients in each case within the required time period. The practice manager endeavoured to speak to patients to avoid an issue escalating into a formal complaint. Staff understood how to de-escalate situations or signpost people if they expressed dissatisfaction in any way. We saw minutes from meetings which evidenced that complaints and concerns were recorded in full detail and discussed at the practice meetings. Information was shared and the practice talked about ways in which the service could be changed to avoid repetition in the future.

# Are services well-led?

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

## Summary of findings

The practice was well led. There were clear lines of management and the vision and purpose of the service was shared by all staff. Governance structures were robust and there was a system in place for managing risks.

However we found that improvements could be made to policies and procedures to ensure that best practice, dissemination of information and learning from events remained consistent across all members of staff.

## Our findings

### Leadership and culture

All staff seemed to follow the vision and values of the practice which were very clear. There was an open and honest culture and clinical, administrative and reception staff all encompassed the key concepts of compassion, dignity, respect and equality. They welcomed input from patients of the practice and acted upon feedback. Staff understood their roles and were clear about the boundaries of their abilities.

Staff we spoke with said they felt very valued. They knew who to go to with any issues or concerns they may have. They said they were listened to and they felt included in decisions about the quality of the service provided.

### Systems to monitor and improve quality and improvement

The partners of the practice understood that there would be a need to replace a member of the leadership staff in the near future when they retired. We discussed with the partners and the practice manager how they would deal with this and they explained that other members of staff were being trained to undertake some of the duties of that person when they left.

All the staff we spoke with told us they were treated fairly and said they found it easy to speak openly and honestly during practice meetings and on a one to one basis with their line manager. This made them feel valued and listened to. The reception and administration staff said they worked well as a team, covered each other's roles and shared information with each other to ensure that the service provided was always the best it could be.

There were systems in place to identify and manage risk, information was shared throughout all staff and action was taken when required to make improvements. Information about incidents and learning did not always reach every member of staff but the practice made every effort to manage this.

The practice undertook quality monitoring audits such as environmental and maintenance checks to ensure that the service provided was satisfactory and effective. However, we found that some checking systems were ineffective. For example it was not clear who was responsible for checking and escalating any concerns associated with fridge

# Are services well-led?

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

temperatures and emergency equipment. We discussed this with the practice manager and one of the doctors during the inspection. The practice manager said they would seek advice to rectify this matter.

### Patient experience and involvement

The practice and all its staff recognised the views of the people who used the service were important. A proactive approach was taken to seek patient feedback through various channels such as the patient participation group, patient surveys, compliments and complaints and comments boxes in the waiting areas. We saw that comments were taken seriously and people were listened to. We saw that changes were made whenever possible and these were fed back to the patients through newsletters and on the website. The staff actively sent newsletters out to patients who did not routinely attend the surgery and were less likely to otherwise receive the information.

### Staff engagement and involvement

Staff were encouraged to attend practice meetings and share their views. We saw that all staff were listened to and their views were important. They were invited to input to improvements of the service provided. Frontline staff were actively encouraged to gain patient feedback in a natural way by asking questions such as "are you happy with the service received today", "is there anything else we can do to help" and "would you like to make any comments or suggestions today". One member of staff explained how they shared good practice with each other and worked together as a team for the benefit of the patients.

### Learning and improvement

There was a robust supervision and support system for staff which included 360 degree appraisal of each other. One-to-one meetings were held where staff were able to discuss whether they were happy in their role, any performance issues and any training requirements. Staff spoken with told us there were "fantastic training opportunities" and the practice manager and senior partners were keen to fill "gaps in service" rather than "jobs" which meant that roles and responsibilities changed to fit service requirements. Staff told us this had a very positive outcome for the patients. Staff were trained in each other's roles so that there were no gaps in service when people were on leave. One member of staff had been supported by the practice to develop from administrator to assistant practitioner.

### Identification and management of risk

Risks were identified and managed by systems in place and through discussion. For example staff were encouraged to attend at practice meetings and highlight any complaints or incidents that had been brought to their attention. Adverse and critical incidents were recorded and reviewed and staff were asked for their feedback. It was evident from the information we were shown that learning was continual and actions were taken to make changes when required. The practice were open to constructive comments and encouraged feedback from patients, local peers, outside agencies and commissioning groups about how they could make improvements.

Significant changes already made included telephones being answered from 8am, an increase in telephone appointments, on line appointments and on line prescription requests introduced, an additional check in point closer to the entrance to the practice and local council input to provide more accessible parking, particularly for disabled patients.

There was also an improvement plan for the rest of the year to introduce a 'Dr First' service, power assisted doors to the surgery entrance, clearer written instructions from hospitals discharging patients, better use of the Walk-in-Centre rather than A&E, a reduction of medicine packaging in order to save resources and all drugs for Tameside residents to be NICE recommended.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Summary of findings

We saw that patients with long term conditions were supported by a system of collaborative care that involved management, follow up and referral to other services, such as secondary or acute care, when required. There was information displayed in the waiting areas and on the practice website explaining different long term conditions in detail and signposting access to other services.

## Our findings

Patients told us they felt safe and they were very complimentary about the treatment they received. The practice evidenced that care was delivered in line with current best practice. There was a range of information displayed in the waiting areas and on the practice website explaining different long term conditions in detail and signposting access to other services. Patients spoken with told us they were regularly recalled for follow up visits and were seen by the most appropriate clinician or health care assistant at each visit. The practice and all its staff recognised and were encouraged to report any comments, complaints and feedback received which could improve the service for patients with long term conditions.

Services for people with long term conditions were effective because care and treatment was being delivered in line with current best practice and there was pro-active engagement with other health and social care professionals. There was considerable information and videos available on the practice website which explained symptoms, diagnoses, treatment and services offered. There was also information signposting patients to other areas for assistance and leaflets in the practice waiting room for those people without internet access.

Services for people with long term conditions were caring. Patients told us they were listened to, treated with respect and were involved in decisions about their care needs. We observed that all patients were spoken to kindly by reception staff and that if someone wished to be seen in private there was a room available for this purpose.

Services for people with long term conditions were responsive. There was active engagement with commissioners to support the provision of care required. Access to the service was made as simple as possible and emergency appointments were always available. We spoke

# People with long term conditions

to three people within this population group and they were very complimentary of the service received. We saw that people were routinely called for follow up and there was a robust system to ensure no one "fell through the net"

Overall services for people with long term conditions were well led. Staff understood the values and ethos of the practice which included key concepts such as compassion, dignity, respect and equality. Staff understood their roles and responsibilities and were able to identify and manage risk. The practice and all its staff recognised and were encouraged to report any comments, complaints and feedback received which could improve the service for patients with long term conditions.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Summary of findings

The practice offered services to mothers and their children in the form of family planning and child health surveillance clinics. There were also clinics led by the practice nurses and vaccination sessions each month.

## Our findings

There were vaccination sessions each month at the surgery to protect the children registered at the practice. If a mother was unable to attend a specific vaccination session then an appointment could be made outside of these times with a practice nurse who would carry out the procedure for them. There are also health visitors, district nurses attached to the practice and contactable at a neighbouring clinic. A group of midwives attended the practice on a rotational basis and appointments are available through the normal channels.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Summary of findings

The practice provided screening programmes, vaccination clinics and various other services. They worked with other health and social care professionals and shared information to ensure that patients received an all round and holistic service relating to their needs.

## Our findings

Overall we found the service for people in this population group to be safe. There were good systems to ensure that complaints were dealt with and we saw that actions were taken when required. We saw that a complaint was made about a lack of GP cover which impacted on home visits and noted a change in practice so that there was a specific doctor to cover home visits on a daily basis. If more home visits were required than could be managed by one GP then the other doctors in clinic would add these to their patient list at the end of their clinic. We saw that patients were protected in emergency circumstances. We spoke with 13 staff. All had been trained in the safeguarding of vulnerable adults and all were able to describe what they would do if they suspected abuse or if an emergency incident arose. However we found that improvements were required to some systems to ensure that patient safety was not compromised by any breakdown in communication about safety. The practice provided screening programmes, vaccination clinics and various other services. They worked with other health and social care professionals and shared information to ensure that patients received a holistic service relating to their needs. There was a late clinic once a week to support people who were not able to take time during working hours to attend appointments.

We found the service for people in this group was effective. Care and treatment was being delivered in line with current best practice and there was pro-active engagement with other health and social care professionals. There was a range of up to date information on different health topics and promotional literature readily available to patients. The practice provided screening programmes, vaccination clinics and various other services working with other health and social care professionals and sharing information.

The service for people in this population group was caring. Patients spoken with told us they were listened to, treated with respect and were involved in decisions about their care needs. We saw that there were systems in place to support people in this patient group and that they were encouraged to make informed decisions about the

# Working age people (and those recently retired)

treatment they received. We spoke to people in this group who had been supported during bereavement and difficult diagnoses and they were extremely complimentary about the service they had received.

Services for people in this patient group were responsive. There was active engagement with commissioners to support the provision of care required by older people. Access to the service was made as simple as possible and emergency appointments were always available. We spoke to six people within this population group and all were extremely complimentary of the service received.

Overall services for older people were well led. Staff understood the values and ethos of the practice which included key concepts such as compassion, dignity, respect and equality. Staff understood their roles and responsibilities and were able to identify and manage risk. The practice and all its staff recognised and were encouraged to report any comments, complaints and feedback received which could improve the service this population group.

# People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Summary of findings

The practice received information from accident and emergency departments at neighbouring hospitals and the information provided details of patients who were registered at the practice some who were people with poor access to primary care. This prompted the practice to proactively try to make contact with those people. However, there were no formal systems in place to reach communities such as gypsies, travellers and sex workers.

## Our findings

Overall we found that the service kept people safe. There was one system in place to reach some vulnerable people who may not otherwise proactively attend the surgery. However the same systems were in place and would be utilised to address incidents, deal with complaints and protect those patients in this group who did use the service. The practice were open and transparent when things went wrong and there were systems to ensure that learning was shared. There was no evidence that the practice pro-actively followed The Royal College of General Practitioners (RCGP) guidance around reaching out to communities such as gypsies, travellers, sex workers and other people in vulnerable circumstances who may have poor access to primary care.

We found that the service was caring towards all patients, and this would include any patient within this population group who did not actively attend the surgery. We saw that staff spoke to all patients with dignity and respect and we observed staff being helpful and patient. Staff told us that if necessary they would speak to any patient in a quiet room so that their privacy could be respected. The clinical staff were able to evidence that all patients were involved in their treatment plans and were supported to make decisions about their care.

We found that the service was effective for some people in this population group. We saw that a homeless person had been contacted and received treatment because of a system in place. However the practice could not evidence that they had systems in place as per RCGP guidance around reaching out to communities such as gypsies, travellers, sex workers and other people in vulnerable circumstances who may have poor access to primary care.

We found that the service was responsive to some people in this population group. The practice manager and one of

# People in vulnerable circumstances who may have poor access to primary care

the GP partners told us about an incident where this information had enabled them to contact the family of a homeless person registered with the practice (whilst maintaining appropriate levels of confidentiality) and subsequently arrange a visit to the practice with the assistance of that family member.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Summary of findings

Patients with mental health problems were able to access a doctor when required in a timely manner and there was information about depression and mental illnesses available on the practice website and in the patient waiting areas. The practice encouraged its patients to complete a depression questionnaire which was available on-line and could be transferred straight to the GP before the patient's next visit. When patients completed this, the reviewing GP always had up to date information about their current mental state.

## Our findings

Overall we found that people experiencing poor mental health were safe. Systems were in place to address incidents, deal with complaints and protect patients with serious mental illness who used the service. We asked staff to describe how they would deal with a person displaying mental health issues either over the telephone or during consultation. Their response gave us confidence that they understood what action to take and how to escalate any issues whilst keeping the patient safe. We saw that staff shared information and learning in this area so that vulnerable people in this population group were protected.

There was information about depression and mental illnesses available on the practice website and in the patient waiting areas and we were told these could be made available in different languages if and when required. We saw a system which evidenced action taken and a change in practice for the better when adverse incidents occurred particularly in relation to this patient group. We saw that clinical audits were undertaken and changes were made when required to ensure that antidepressant medicine was prescribed according to best practice

We found that the service was caring towards all patients including patients experiencing poor mental health. We saw that staff spoke to all patients with dignity and respect and we observed staff being helpful and patient. The clinical staff were able to evidence that all patients were involved? in their treatment plans and were supported to make decisions about their care.

We found that the service was effective for people experiencing poor mental health. We saw that a serious adverse event relating to a person with mental illness had been reported and the required changes to practice had been made.

We found that the service was responsive to people experiencing poor mental health. One member of staff explained how they had helped a patient to gain access to a telephone consultation before they received a change in

# People experiencing poor mental health

their anti depressant medicine. When the person then spoke with the doctor it was felt that a face to face appointment was required and an immediate space was made so that the person could be seen without delay.

The service for people with poor mental health was well led. Reception, administration and nursing staff we spoke with were clear about their level of authority and knew how, when and to whom any concerns about patients with mental health issues should be escalated. We saw evidence that clinical audits were undertaken. In particular an audit was carried out in September 2013 around the safe prescribing of Citalopram which is an antidepressant medicine. This identified two cases which required review and ensured that the practice continued to prescribe this medicine according to best practice guidance.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Family planning services | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage the storage of medication as per the cold chain policy. |

| Regulated activity | Regulation |
|---|---|
| Maternity and midwifery services | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage the storage of medication as per the cold chain policy. |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage the storage of medication as per the cold chain policy. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. |

This section is primarily information for the provider

# Compliance actions

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage the storage of medication as per the cold chain policy.