Manor House Surgery Hadfield

Quality Report

82 Brosscroft
Hadfield
Derbyshire
SK13 1DS
Tel: 01457 860860
Website: www.manorhousesurgery.co.uk

Date of inspection visit: 23rd April 2015
Date of publication: 12/06/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9
Outstanding practice	9

Detailed findings from this inspection

Our inspection team	11
Background to Manor House Surgery Hadfield	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Manor House Surgery Hadfield on 23rd April 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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 had a very active patient participation group and feedback sought from patients and staff was acted upon.

We saw some areas of outstanding practice :

The practice had a system whereby patients could access their own medical records from their home computers and through their smart phones. Around 100 patients were using this service and the patient participation

Summary of findings

group were helping to educate patients about the advantages such as managing appointments on line, reviewing blood and test results and direct access to a nurse or doctor with a query without making a telephone call or an appointment.

There was a patient information room at the practice with A-Z health information available in structured folders offering advice and education and encouraging self management of long term conditions and other minor ailments. There were comfortable chairs, access to a computer, a blood pressure monitoring machine and weighing scales.

A member of the patient participation group (PPG), with help and support from the lead GP, had attended training and set up a patient support group to provide talking therapy support for patients waiting a long time for referral to psychology services. The PPG was heavily supported by the GPs and staff at the practice.

We saw an area where the provider needs to make improvements.

The provider should:

- Ensure that all members of staff who carry out chaperoning duties have received a Disclosure and Barring Service (DBS) check.
- Ensure that all staff files have a record of the required documentation to evidence proof of their identity and their employment history.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Most of the staff had been employed for over five years. Recruitment processes were in place and we saw evidence of appropriate documentation for newly recruited staff. Some staff undertook duties which required a Disclosure and Barring Service (DBS) check and this had not obtained. There were enough medical, nursing and administration staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. A dedicated nurse and the assistance of a pharmacist had been commissioned to improve service and support for older people, specifically those over the age of 75. The pharmacist was reviewing those on complex medicines and provided advice on prescribing. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances and children living in nearby children's' homes. There were set clinics for childhood immunisations and immunisation rates were relatively high for all standard childhood immunisations. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice nurse had been trained so that immunisations, eight week baby checks, family planning and post natal checks could all be done in one joint Nurse/ GP family planning clinic. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. A patient information room was available in the reception area with A-Z information on all health related topics, the use of a computer, scales and a blood pressure monitoring machine, information about the patient participation group (PPG), requests for patient feedback and many signposts to health living activities and support organisations in the community. The practice also offered online services that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They held a register of vulnerable patients including patients living in a women's refuge, patients living in nursing homes and those with learning disabilities. They carried out annual health checks for all patients with learning disabilities and regularly reviewed their medicines. Longer appointments were available on request. The practice held Gold Standard Framework meetings where the care of vulnerable patients and patients with long term illnesses were discussed. These meetings were attended by multi-disciplinary health and social care workers. They also worked with their PPG to raise awareness of support groups and voluntary organisations for socially isolated and vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of patients experiencing poor mental health and offered an annual health check including a review of medicines. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia. They undertook a range of enhanced services such as dementia identification and admission avoidance.

Summary of findings

Not all staff had received formal training on how to care for people with mental health needs and dementia. However when questioned they expressed knowledge and understanding of what to do in given situations.	

Summary of findings

What people who use the service say

We spoke with six patients and reviewed comments from 49 Care Quality Commission (CQC) comments cards which had been completed. Most of the comments were positive. The patients we spoke with face-to-face had all telephoned in for their appointment on that day and had no trouble getting one. Three of the comments cards mentioned that sometimes it can be difficult to get an appointment and one comment stated they felt rushed. All the patients spoke very highly of all the staff and in particular praised the receptionists for their kindness and patience. Other comments included praise for the GPs who were said to be thoughtful, thorough and good at putting patients at ease. The online service for appointments and repeat prescriptions was reported to be effective.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary although one person thought there was not enough privacy for private conversations at the reception desk. All patients were satisfied with the cleanliness of the environment and the facilities available.

We reviewed the results from the latest GP Survey which received a 37% completion rate. The practice scored higher than the local CCG average in all aspects :

100% of the respondents said the last GP they saw or spoke to was good at listening to them and 100% had confident and trust in the last GP they saw or spoke to. 99% described their overall experience of the surgery as good. The areas where the practice scored best compared to the Clinical Commissioning Group were as follows :

84% usually got to see or speak to their preferred GP compared the CCG average of 59%. 97% found it easy to get through to the surgery by phone with the CCG average at 75% and 93% described their overall experience of making an appointment as good, compared to 72% for the local average. Responses about nurses were all higher compared to the local average.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all members of staff who carry out chaperoning duties have received a Disclosure and Barring Service (DBS) check.
- Ensure that all staff files have a record of the required documentation to evidence proof of their identity and their employment history.

Outstanding practice

The practice had a system whereby patients could access their own medical records from their home computers and through their smartphones. Around 100 patients were using this service and the patient participation group (PPG) were helping to educate patients about the advantages such as managing appointments on line, reviewing blood and test results and direct access to a nurse or doctor with a query without making a telephone call or an appointment.

There was a patient information room at the practice with A-Z health information available in structured folders offering advice and education and encouraging self management of long term conditions and other minor ailments. There were comfortable chairs, access to a computer, a blood pressure monitoring machine and weighing scales.

A member of the PPG, with help and support from the lead GP, had attended training and set up a patient

support group to provide talking therapy support for patients waiting a long time for referral to psychology services. The PPG was heavily supported by the GPs and staff at the practice.

Manor House Surgery Hadfield

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a nurse adviser.

Background to Manor House Surgery Hadfield

Manor House Surgery Hadfield is one of two practices that share management, governance and some staff across two sites. Each practice is independently registered with the Care Quality Commission and works as a practice in its own right. Manor House Hadfield works under a GMS contract and is led by a female GP partner carrying out seven clinical sessions per week. She is supported by two male GPs each carrying out one session per week as well as an ST3 (a doctor in their final year of training) and a fourth year medical student. The practice serve a population within Glossop and Hadfield and have a stable list of around 3,000 patients.

The building complies with the Disability Discrimination Act 1995 (DDA). All consulting rooms are on the ground floor with corridors and doors wide enough for wheelchairs. Car parking is available on site. The practice offers an open list and welcome new patients living or moving to the area. They are aware of new housing within the area.

Services offered include chronic disease management, childhood vaccinations, six week baby assessments, nurse clinics and travel vaccinations. Patients also have access to ultrasound services, echocardiograms, cardiac event recording, dermatology, minor surgery, specialist basal cell carcinoma surgery, joint injections, anticoagulation and family planning.

The practice is open Monday to Friday from 8.30am until 6pm with early opening at 7.15am on a Tuesday. On Tuesdays the telephone lines do not open until 8.00am and on Thursday afternoons the surgery is open for administration only, such as booking appointments and collection of prescriptions. Appointments and prescription requests can be made over the telephone, online or by attending at the surgery.

The practice has opted out of providing out-of-hours services to their own patients and information on how to access services at these times is available to patients on the practice website, in patient leaflets and over the telephone.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. There were no previous performance issues or concerns about this practice prior to our inspection. We carried out a comprehensive inspection of the service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23rd April 2015. Before our inspection we liaised with the practice manager who was on annual leave at the time of the visit. During our visit we spoke with the provider, the lead GP partner and one other GP partner. We briefly spoke with a visiting GP carrying out a dermatology clinic. We interviewed the practice nurse, health care assistant and several reception/administration staff. We also spoke to five patients and reviewed 49 CQC comments cards. We met with the Chairman and one other member of the patient participation group (PPG) and observed how people were being cared for.

Good

Are services safe?

Our findings

Safe track record

We saw that the practice used a range of information to identify risks and improve quality in relation to patient safety. These included significant events, national patient safety alerts and comments and complaints received from patients which were all appropriately recorded. The lead GP took responsibility for checking NHS websites for national safety alerts and shared this information with the other clinicians as required. We saw evidence of this from meeting minutes.

Staff we spoke with understood their responsibilities to raise concerns and knew how to report incidents and near misses. We were given examples of two incidents that had occurred in the previous twelve months and were shown how this had been investigated. Action had been identified following investigation and the partners and practice manager had discussed what was required to limit the chance of the incident occurring again in the future.

All information relating to safety records was stored on a drive accessible by all staff. We saw safety records, incident reports and minutes of meetings where significant events were discussed during previous years. This showed the practice had managed these consistently over time and evidenced a long term safe track record.

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 during the preceding year and we were able to review these. Significant events were a standing item meeting agendas and were discussed with all relevant staff. We saw evidence that the practice learned from incidents and put measures in place to reduce future re-occurrence.

All staff knew how to record and report incidents and showed us how they would access the form from their desktop and escalate it to the necessary lead. Patient alerts were noted on patient records and any prescription errors were flagged on the clinical system (EMIS web). The practice worked closely with local pharmacies to minimise errors in medication and information was cascaded to all staff at regular staff meetings.

We saw that where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We also saw that local protocols were introduced to minimise the risk of the event happening again in the future and these were shared with the Clinical Commissioning Group (CCG) to enhance good practice across the board.

Reliable safety systems and processes including safeguarding

There were systems in place to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff were trained to a level appropriate to their role and had recently undergone an awareness session provided by the locality safeguarding lead. Staff spoken with knew how to recognise signs of abuse in older people, vulnerable adults and children and were aware of their responsibilities to share, record and document information. Out of hours contact details were easily accessible.

The main GP partners took the lead for safeguarding vulnerable adults and children and attended CCG meetings. They were trained and demonstrated knowledge to enable them to fulfil this role. Over the previous two years they had increased multi-disciplinary working and had regular contact with safeguarding departments at Derbyshire County Council, health visitors, the school nurse and safeguarding nurse for looked after children. All the practice staff were aware of and worked closely with two local children's homes and a women's refuge.

Electronic patient records had alerts and GPs used required codes to highlight vulnerable patients. They ensured that risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Evidence of alerts and relevant information on patient records was available to staff when patients attended appointments.

GPs supplied information as requested to local case conferences for patients registered at their practice and attended meetings if their workload allowed. We were told of a safeguarding incident and saw evidence of the same recorded on the patient record. The records corroborated what we had been told and we saw that the incident had been followed through time. The practice nurses also provided examples of safeguarding issues and excellent communication within the practice to follow up any issues.

Good

Are services safe?

There was a chaperone notice and policy, which was visible in the waiting room and in consulting rooms. (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 nursing staff usually acted as chaperone; however reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However Disclosure and Barring Service (DBS) checks had not been carried out on all staff who performed chaperone duties.

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 ensuring that medicines were kept at the required temperatures, which described the action to take in the event of any potential failure. The practice staff followed the policy. There was a system to ensure medicines in GP bags were kept up to date and we saw an email from the practice manager to one of the GPs informing them when a date was due to expire. We checked the GPs bags and saw that all medicines were in date.

We saw two full cycle clinical audits which had been carried out to see whether the practice were adhering to guidelines in respect of the prescription of medicines for sickness and for chronic heart failure. All GPs spoken with were aware of these audits. Actions had been identified and a protocol put in place to ensure that when these medicines were prescribed, patients were made aware of any risks involved and these were noted on the patient record.

The nurses administered vaccines using directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines such as antidepressants or tranquilizers and this included regular monitoring in line with national guidance. Appropriate action was taken based on the results and prescriptions could not be unconditionally repeated without regular reviews. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms were kept in a locked drawer and logged in and out appropriately. Prescriptions used in the electronic system were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients on repeat prescriptions were called for an annual appointment to review their medicine and make sure it was still required.

GPs discussed actions taken in response to reviews of prescribing such as patterns of antibiotics, hypnotics and sedatives. The assistance of a pharmacist had been procured specifically to review medicines in patients over the age of 75 and reduce or optimise them where possible.

Cleanliness and infection control

The practice had a lead for infection prevention and control (IPC) which carries the responsibility of obtaining regular IPC updates, keeping staff informed, updating staff training and sharing advice on the practice infection control policy. We saw that an in-house infection control audit had been carried out by the infection control lead and had identified minor areas which had been addressed. There had been no request for support from the CCG to carry out an independent IPC audit of the practice within the last twelve months.

Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. We saw that beds were wipeable and covered with disposable protectors, pillow cases were disposable and curtains were non-disposable. Disposable equipment was used for minor surgery and other treatment related procedures. A nurse spoken with said they were also responsible for cleaning their own equipment such as auroscopes and spirometers (equipment used for looking in people's ears and checking people's breathing) but this was not documented. We discussed this during the feedback and following the inspection we received evidence that a check list had been put in place to document that these items were being cleaned.

We saw evidence that staff had completed training on infection control and hand washing. Two of the non-clinical staff we spoke to in detail, expressed knowledge of what to do in the event of a spillage of urine, blood or vomit and assured us that spillage kits were available. Nursing staff spoken with were aware of what was required to keep the

environment infection free. We saw that advice had been shared with all staff by the lead GP on the isolation of patients with low immunity or those with suspected infectious diseases such as Ebola. We saw that infection control matters were raised and documented in meeting minutes when required.

The IPC policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. This provided guidance on specific situations, for example, use of personal protective equipment, dealing with spillage of blood and responding to a needle stick injury. We saw there were adequate supplies of equipment available to staff to enable them to follow the protocols. Staff were able to describe how they would use these to comply with the practice's infection control policy although no formal training had been undertaken. Notices about hand hygiene and appropriate hand washing and alcohol gels were available in treatment rooms.

We observed the premises to be clean and tidy and cleaning was carried out by an external provider. Following the inspection we received evidence of cleaning schedules completed by the cleaning providers to ensure that cleaning was carried out effectively on a daily basis. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Maintenance of equipment was the responsibility of the Estates and Finance Managers for the practices. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The next date for testing was July 2015. There was a blood pressure monitoring machine and weighing scales in the patient information room in reception and we did not see evidence that these pieces of equipment had been calibrated during the last test.

Portable appliance testing was no longer carried out following guidance from the health and safety executive in 2012 and the practice had a protocol to support this. However we did not see documented evidence of regular in-house checks to ensure portable appliances remained safe.

All equipment used for minor surgery was single use and was checked for the expiry date before use and safely and securely disposed of after use in line with practice policy.

Staffing and recruitment

Records we looked at during the inspection did not contain evidence that all appropriate recruitment checks had been undertaken prior to employment such as proof of identification, references and criminal records checks through the Disclosure and Barring Service (DBS). However, these were records of staff who had been employed by the practice for over ten years. We received evidence that appropriate checks and the required documentation had been received for newly appointed staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff and stated that DBS checks would be carried out dependent on the role of the employee. We highlighted that staff who carried out chaperone duties required a DBS check and were assured that this would be done going forward.

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 rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts and we saw documented evidence that new staff received an induction.

Staff felt there was enough of them to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had robust systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and the maintenance and calibration of equipment. The practice also had a health and safety policy with clear lines of responsibility for specific members of staff. These included

Good

Are services safe?

fire risk assessments, quarterly checks of escape routes, maintenance of fire extinguishers, regular fire alarm tests, emergency lighting, ladders and panic button tests. We saw evidence that checks were carried out on a regular basis and that actions were taken if and when required.

We found that calibration records needed to be updated to include all equipment at the practice and we did not see documented evidence that regular risk checks had been carried in relation to portable appliances which were no longer independently checked by a qualified electrician.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. One member of staff told us about a medical emergency concerning a patient and explained what action had been taken which was appropriate. The practice had discussed the event and shared learning from it. Recent CPR training had led the practice to improve their emergency equipment bags to stream line them and ensure that the equipment was quick to access. They had changed their nebuliser machines (used to help with breathing difficulties) and replaced them with single use nebulisers through oxygen which were more hygienic and effective.

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 in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer such as heating and electrical companies. Copies of the document were kept safely at the homes of the GP partners.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were included in the health and safety protocol.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke were able to explain the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Minutes of practice meetings showed that clinical issues and updates on guidance were discussed. Staff spoken to and evidence reviewed corroborated that the actions taken by the lead GP were aimed at making sure that each patient was given support to achieve the best health outcome for them. We saw evidence that all required staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

The practice had created a home blood pressure monitoring record for patients to assist in the diagnosis and evidence based management of blood pressure and this had been done following on from guidelines about hypertension in patients.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. In addition the lead GP summarised any new evidence or updates and shared them with relevant practice staff.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. They had achieved full points for the quality and outcome framework (QOF) which is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs 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. Input from a pharmacist had been dedicated to review all patients over the age of 75 and educate the practice about complex medicines and prescribing advice.

Information and advice was collected and collated and used to inform clinical audits. We saw examples of two full cycle clinical audits around medicines. In addition a full cycle audit had been done to review and improve standards of care around the use of medicines with contra indications in patients over the age of 65. The audit had been re-done on two occasions showing positive improvements each time. The ST3 doctor (a doctor in their last year of training) had completed an around anti-psychotic monitoring. Other audits were often linked to medicines management advice received through prescribing updates from the CCG or as a result of information from QOF.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Patients with diabetes had an annual medicine review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and cervical screening. The practice had been accredited in services such as ring pessary fitting, minor surgery and family planning procedures. Accreditation is a formal, third party recognition of competence to perform specific tasks.

There was a protocol for repeat prescribing which was in line with national guidance. Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support

Good

Are services effective?

(for example, treatment is effective)

needs of patients and their families. There was also a lists of patients with long term conditions which showed excellent evidence of links to multi-disciplinary teams and referrals to other associations such as the Alzheimer's Society for patients suffering from Alzheimer's.

Effective staffing

We saw that appraisals were carried out annually on all staff and training plans and personal objectives were respected and encouraged. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff recently received equality and diversity training and a full review of safeguarding by the local council safeguarding lead. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The practice were regularly reviewed by the Deanery and had received a gold award as a result of positive feedback given by students during their community placements at the practice. .

Practice staff included GPs, nurses, managers, clerics and receptionists. Records reviewed showed that staff were up to date with most mandatory courses such as annual basic life support, safeguarding, fire and health and safety. Documentation to support evidence of training in infection control was sent to us immediately following the inspection.

The lead GP had a specific interest in safeguarding and the practice were in the process of implementing training in mental capacity and deprivation of liberty safeguards (DoLS). We were shown several examples where this interest had provided positive outcomes for patients.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated in 2012/2013. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as review of patients with long term conditions were also able to demonstrate that they had appropriate training to fulfil these roles. However the lead for infection control had not completed training required to lead in this role.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by fax. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. A member of staff was able to explain what happened when they thought information about a patient had been missed. Their prompt action and escalation of their concern had led to a positive outcome for the patient concerned.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Consultation with other health and social care professionals about patients included work with district nurses, health visitors, social care services, safeguarding teams, mental health consultant professionals, school nurses and McMillan nurses. We saw that information was shared and used appropriately.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Choose and Book was also in place for routine referrals and staff found it useful. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patients referred to A&E were provided with a summary from the electronic system and staff told us that the GP often also wrote an additional letter to ensure that all information was available.

Good

Are services effective?

(for example, treatment is effective)

The practice had a system whereby patients could access their own medical records from their home computers and through their smartphones. The lead GP was very instrumental in promoting this and around 100 patients were using the service. It allowed them to manage their appointments and blood results on line and also enabled them to ask questions of the GP or nurse without having to book an appointment. In the future it was hoped that on-line consultations may be available. The patient participation group (PPG) were helping to educate patients about the advantages of this service.

There were excellent systems in place to provide staff with the information they needed. All staff were trained on the electronic patient record used to co-ordinate, document and manage patients' care. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that electronic records were audited to ensure security and regular checks carried out by the Deanery (because the practice was a training practice) to ensure that information such as read codes and summaries were up to date and appropriate. The practice used various electronic applications to support their clinical practice such as emis mentor, scripswitch and an approved antibiotic application.

Staff internal information systems included access to shared computer drives and all staff were aware of information on the system and how to retrieve it when needed. We asked for several documents to support our findings throughout the inspection and the information was quickly and easily retrievable when requested.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and good explanations were given of how these were implemented in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had recently developed capacity assessment forms and best interest decision forms. These had just been developed and were being discussed at the next clinical meeting. Training in mental capacity had been organised for clinicians in this area and information, guidance and advice would then be shared with other staff. This training would enhance staff knowledge when supporting patients to make decisions around do not attempt cardiopulmonary resuscitation orders (DNACPR).

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples on these plans on patients' records.

There was a consent policy in place which described the different types of consent and provided staff with awareness in this area. Different staff we spoke understood the need for consent and all clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

There was a patient information room at the practice with A-Z health information available in structured folders which were easily accessible and identifiable. Comfortable chairs and access to a computer had also been supplied for patients use. In addition there were structured notice boards with information on specific subjects and signposts to most support services. There was a walking group organised by the patient participation group (PPG) and other health events where GPs have provided health information such as prostate awareness, diabetes, dermatology and women's' health. There was access to a blood pressure machine and weighing scales and instructions on how to use them. We saw a lot of information providing health education and ways of self-management. A member of the PPG had attended training and set up a patient support group to provide talking therapy support for patients waiting a long time for referral to psychology services.

Good

Are services effective?

(for example, treatment is effective)

The lead GP felt the practice were in an excellent position to promote healthier lives due to the stability of practice staff and their knowledge of their patients. They also tried to lead by example. Each patient contact offered a holistic approach to the patient's health and opportunistic health checks were carried out. One patient we spoke to, attending for a routine appointment, had received a full check-up and had been booked in for another appointment the following week to review blood and other test results. Health Care Assistants led on smoking, alcohol and obesity and we saw information advertising this service in the patient information room.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice took pride in treating patients with kindness, dignity and respect and this was evidenced in different forms of feedback. Staff knew patients well and patients reported that they were treated respectfully and with compassion. All five patients we spoke to said the practice offered an excellent service and staff were efficient, helpful and caring. Forty-nine CQC comments cards were completed and all complimented the staff, the treatment and the environment.

We reviewed the most recent data available for the practice on patient satisfaction which included information from the 2015 national patient survey. We also reviewed practice patient satisfaction surveys and a report following a patient satisfaction questionnaire carried out in 2013/14 about the overall service provided by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated better than average in all aspects. 100% of the respondents said the last GP they saw or spoke to was good at listening to them, 100% had confident and trust in the last GP they saw or spoke to and 99% described their overall experience of the surgery as good.

There was no glass partition to help keep information private at reception. Patients acknowledged this but did not respond with any negative comments about privacy. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments at reception so that confidential information was kept private as much as possible.

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. Data from the national patient survey showed 93% said the GP was good at giving them enough time and 95% reported that the GP was good at explaining tests and treatments. The same results were reported for the nurse at the practice.

Patients we spoke with 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 comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language and a member of staff was fluent in several languages although there was little diversity within the practice population.

There was evidence that older people were very well supported with the use of care plans and helped to understand information about long term conditions and end of life planning if appropriate. Patients with long term conditions reported good long term support and families and young children were supported and treated appropriately.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that all the staff were able to provide emotional support. One of the GPs described incidences when they had gone over and above expectation to support a person with their treatment as did two of the reception staff. Patients we spoke to said they always had enough time to discuss their problems and could make longer appointments if they needed them. We saw that staff who spoke with patients over the telephone were knowledgeable and helpful and were able to conclude some consultations without the need to bother a GP or nurse. These included discussions around repeat prescriptions, queries about test results and how to access secondary services or other support services available.

Counselling and psychological well-being services were available within the CCG and the waiting times for these services and for cognitive behaviour therapies (CBT) were quite long. As a result of this the patient participation group (PPG) had arranged a support group and provided an outlet for patients whilst they were waiting for appointments. Bereavement counselling was offered by

Good

Are services caring?

the GPs and patients notices in the patient information room, on the TV screen and patient website told patients how to access a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and there were systems in place to maintain the level of service provided. GPs had lead roles for specific conditions such as dermatology, chronic diseases, prescribing and minor surgery. Nurses also had lead roles in chronic disease management. There was a system in place to ensure that patients with long terms conditions had regular appointments to review and monitor their conditions. Medicine reviews were arranged at appropriate intervals and regular health checks were offered and provided. Patients with complex needs had a named GP and practice nurses worked with multi-disciplinary teams to provide support.

Patients over the age of 75 had a named GP and proactive personalised care plans to reduce unplanned admissions to hospital. The practice participated in a range of services including dementia and end of life care and worked closely with local nursing homes.

Appointments were available outside of school hours for families with young children and the GPs and nursing staff worked closely with midwives and health visitors. There was a register of people living in vulnerable circumstances such as children's homes and a women's refuge or those patients living in nursing homes with dementia or mental health conditions.

GPs engaged with the Clinical Commissioning Group (CCG) to discuss local needs and areas of priority. The practice also implemented suggestions for improvement and made changes to the way it delivered services in response to feedback from patients and the patient participation group. Examples included working with patients to reduce inappropriate home visits, training staff to support deaf patients and educating patients about their entitlement to privacy, by placing notices in the reception area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services such as those with disabilities or living in vulnerable circumstances. Although there was little diversity with the practice population, there was access to online and telephone translation services if required. Staff had not received formal equality and diversity training however those we spoke with were clear about the different needs of different cultures, religions, gender and/or sexual preferences. All patients were treated equally.

The premises and services had been adapted to meet the needs of patient with disabilities and access was available to wheelchairs and disability scooters. The waiting area was large enough to accommodate wheelchairs and prams and there was easy access to treatment and consultation rooms. There was an accessible toilet and facilities available for nursing mothers.

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. Longer appointments were also available on request for those patients who needed them and home visits were made when required.

The practice was open Monday to Friday from 8.30am until 6pm with early opening at 7.15am on a Tuesday. On Tuesdays the telephone lines were not open until 8.00am and on Thursday afternoons the surgery was open for administration only, such as booking appointments and collection of prescriptions. Appointments and prescription requests could be made over the telephone, online or by attending at the surgery. Telephone consultations were available daily.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received evidenced that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. All the patients we spoke with had telephoned and received an appointment on the day of our visit.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

We saw that information was available to help patients understand the complaints system via posters and information through the patient participation group (PPG).

Patients we spoke with said they would refer any comments to the practice manager or any of the reception staff and felt comfortable and encouraged to do so. None we spoke with had made any formal complaints.

We looked at a number of complaints received in the last 12 months and found they were dealt with satisfactory and openly. The practice reviewed complaints annually to detect themes or trends and shared these with the CCG. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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

All practice staff were encouraged by the lead GP to deliver high quality care and promote good outcomes for patients. The lead GP attended locality and Clinical Commissioning Group (CCG) meetings to identify needs within the community and shared information with all practice staff. Details of future planning evidenced that the practice aimed to correspond with the needs of the population and deliver a service which met those needs. Their vision and values offered patients a level of service which met their needs, offered them dignity and respect and kept them well.

All the staff we spoke to shared the values promoted by the practice, knew their responsibilities in relation to them and told us how they would put them into practice. Most of the staff had been employed by the practice for many years and were familiar with the patients and their level of need. We saw that reception staff specifically treated patients with kindness and empathy and helped them as much as possible.

Governance arrangements

There were satisfactory policies and procedures in place to govern activity, all staff knew how to access them and showed us they were available on any computer within the practice. The staff had access to shared drives where information about meetings and other important information was stored and available for reference at any time. Staff were informed when policies were updated or reviewed and all policies we looked at were current. There was a clear health and safety policy and details of persons in lead roles to report to and ensure day to day safety within the practice.

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 monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurses had a good peer review system within the practice but there was little opportunity to network outside of the practice. Nurses had not been involved in any audits in the past twelve months. GPs and trainees however had an ongoing programme of clinical audit which it used to monitor quality and systems and to identify where action should be taken. One of the trainee GPs had completed an audit on antipsychotic medication and created a system to monitor bloods for patients on this medication which eventually became a system adopted by Tameside Hospital NHS Foundation Trust and other practices within the CCG.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. This structure was newly implemented and was, according to staff, beneficial. All staff we spoke to knew who the leads for safeguarding and infection control were and also who to speak with if they had personal concerns. The lead GP told us they offered an open door policy and staff corroborated this stating they could speak to them, or any other member of staff in a senior or peer role without discomfort or repercussion.

We saw from minutes that whole practice meetings were held regularly and staff told us that there was an open culture with an opportunity to raise their ideas and issues which they felt would be acted upon.

We discussed induction, the management of sickness and disciplinary procedures with a member of staff. They said they understood their responsibilities and were aware of protocols for whistleblowing or raising concerns. They were able to access policy and procedure on their computer desktop.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through many avenues such as Family and Friends survey, internal patient surveys, a suggestion box, comments and complaints and a very active patient participation group (PPG), encouraged and supported by the GPs and staff at the practice. The PPG worked very hard to encourage membership, increase awareness and reached out to younger patients and those in vulnerable circumstances to request their involvement. The GPs meet with the PPG monthly on a formal and an informal basis.

In response to feedback from patients through the PPG the practice have provided health advice on ear syringing, devised letters to patients to help the surgery reduce inappropriate home visits and DNAs, helped the practice to

Are services well-led?

Good

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

arrange Health events to increase awareness in things such as skin conditions, prostate problems, women's health problems and diabetes. The GPs attend these events, give presentations and provide advice and support to patients suffering from these conditions.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice took part in the education of doctors in training from medical students up to final year GP trainees. They were reviewed and accredited by the Deanery and we saw copies of positive feedback from both trainees and their supervisors.

Reviews of significant events and other incidents were shared with staff across the Hadfield and Glossop sites and discussed where practice could be improved or changed. We saw that changes were implemented accordingly. The practice engaged in peer review within the CCG on referrals and elective admissions to ensure they were appropriate. They took action and advice when appropriate and made changes where required.