

# Manchester Road Surgery

## Quality Report

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Warrington  
Cheshire  
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Website: N/A

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

This is the report from our inspection of Manchester Road Surgery. The Manchester Road Surgery is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 12 May 2015 at Manchester Road Surgery. We reviewed information we held about the services and spoke with patients, GPs, and staff.

Overall the practice is rated as good.

Our key findings were as follows:

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care.

- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.

- The practice was responsive and acted on patient complaints and feedback.

- The staff worked well together as a team.

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

The provider should:

- Carry out regular fire drills
- Hold more regular staff meetings with fixed agendas in able to cascade information from learning from events such as complaints for example, to the whole staff team.
- Ensure all staff receive up to date training around the Mental Capacity Act.

**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?

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 but greater use of staff meetings could be made to ensure the whole practice team were aware of any incidents. Information about patient safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. The practice had a fire risk assessment but needed to carry out regular fire drills.

Good



### Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their role.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others in the local area some aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture.

Good



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

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and learning points from complaints were acted on.

Good



### Are services well-led?

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice were in the process of establishing a virtual patient participation group to seek patient feedback. Staff had received inductions, regular performance reviews and training.

Good



# 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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, the avoidance of unplanned admissions scheme. The practice had a designated named GP for patients who are 75 and over. The practice carried out home visits and also visited four local nursing homes on a regular basis.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice had adopted a holistic approach to patient care rather than making separate appointments for each medical condition. Clinical audits were carried out to ensure patients were receiving optimal care, for example diabetes management.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. One GP was the safeguarding lead for the practice. There were systems in place to identify and follow up children living in disadvantaged circumstances. The midwife visited the practice once a week and there were immunisation clinics.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered late evening appointments once a week for those patients who could not attend during the day.

The practice offered online prescription ordering and online appointment services. Telephone consultations were available instead of patients having to attend the practice

Good



### People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. A benefit of being a small practice was that staff knew patients and their families well and arranged appointments to suit patients' needs.

Good



# Summary of findings

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services.

Good



# Summary of findings

## What people who use the service say

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection.

We received 17 comment cards and spoke with three patients. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Patients informed us that they were treated with compassion and that GPs went the extra mile to provide care when patients required extra support.

For the surgery, our findings were in line with results received from the national GP patient Survey. For

example, the latest national GP patient survey results showed that in January 2015, 95% of patients described their overall experience of this surgery as good (from 110 responses) and 98% found the receptionists helpful (which is higher than the local average).

Results from the national GP patient survey also showed that 96% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 95% had confidence and trust in the last GP they saw or spoke to which is higher than the national average.

## Areas for improvement

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

- Carry out regular fire drills.
- Hold more regular staff meetings with fixed agendas in able to cascade information from learning from events such as complaints for example, to the whole staff team.
- Ensure all staff receive up to date training around the Mental Capacity Act.

# Manchester Road Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

a CQC Lead Inspector and a GP specialist advisor.

## Background to Manchester Road Surgery

The Manchester Road Surgery is located in a busy high street in Warrington and is a family run practice that has been established for many years. There were approximately 3000 patients on the practice list and the majority of patients were of white British background.

The practice has two female GP partners. In addition there is one female salaried GP and a female locum GP available. There is a nurse practitioner and reception and administration staff including a practice manager. The practice is open 8.30am to 6.00pm Monday to Friday. The practice offers an extended hours service for those patients who cannot attend during normal working hours every Thursday until 8.00pm. Patients requiring a GP outside of normal working hours are advised to contact the surgery and they are then directed to contact the local 111 service to triage their symptoms and be forwarded to an external out of hours service (provided by Bridgewater Community Trust).

The practice has a PMS contract and also offers enhanced services for example; various immunisation and avoidance of unplanned hospital admissions schemes.

## Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

## 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)

## Detailed findings

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out

an announced visit on 12 May 2015. We spoke with a range of staff including two GPs, the nurse practitioner, reception staff and administration staff and the practice manager, on the day. We sought views from three patients and looked at comment cards and reviewed survey information.



# Are services safe?

## Our findings

### Safe track record

There was a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process. NHS England and the Clinical Commissioning Group had no concerns about this provider.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they felt encouraged to do so.

Staff meetings were held when necessary but did not have fixed agendas to discuss learning from complaints or incidents. The practice manager and staff told us that learning points were cascaded via email to the relevant staff depending on the nature of the complaint or incident. We viewed documentation for significant events which included details of the events and learning outcomes for what could be improved.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

### Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. There were flowcharts on display in the treatment rooms and reception area outlining the safeguarding procedure and who to contact for further guidance if staff had concerns about a child's welfare. There was a lead member of staff for safeguarding.

All staff had received safeguarding children training at a level suitable to their role, for example the GPs had level three training. Staff had also received safeguarding

vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were identified as at risk.

The nurse practitioner and reception staff acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. All staff who acted as chaperones had received a disclosure and barring check.

### Medicines management

The practice worked with pharmacy support from the local CCG. The practice employed a medicines co-ordinator and regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines.

The practice had two fridges for the storage of vaccines. The nurse practitioner took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely and available in the treatment room area. In addition there was emergency adrenalin available in each consultation room. The nurse practitioner had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

### Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available.

## Are services safe?

Clinical waste disposal contracts and facilities were in place and spillage kits were available. Staff knew what to do in the event of a sharps injury and appropriate guidance was available.

One of the GP partners and the nurse practitioner were the designated clinical leads for infection control. There was an infection control policy in place and staff had received up to date training. The practice had carried out a legionella risk assessment. The practice took part in annual external audits from the local community infection control team and acted on any issues where practical for example the practice had provided disposable curtains in treatment areas in response to audit action points.

### Equipment

All electrical equipment was checked to ensure the equipment was safe to use.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

The nurse practitioner carried out regular checks on emergency equipment such as the defibrillator.

### Staffing and recruitment

Staff told us there were enough staff to cope with the needs of patients. Staff covered for each other in the event of unplanned absences. The practice occasionally used GP locums and appropriate recruitment checks, induction and supervision were carried out for all GP locums.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff working at the practice had received a disclosure and barring service check to ensure they were suitable to carry out their role.

### Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff. There was a fire risk assessment in place, however the practice had not carried out any recent fire drills but all staff we spoke with knew what to do in the event of fire. Fire equipment was checked annually. The practice also had a variety of other risk assessments and audits in place to monitor safety of the premises such as infection control.

### Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen. There was also a first aid kit and accident book available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and we found staff were aware of the practicalities of what they should do in the event of a major incident.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Once patients were registered with the practice, the nurse practitioner carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register.

The practice took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings and ensured care plans were in place and regularly reviewed.

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

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The latest QOF points as a percentage of the total available showed the practice to have scored 99% which was higher than the national average of 94.2%.

All GPs and nursing staff were involved in clinical audits. Examples of audits included various medication audits. Some examples of audits we saw were aiming to improve care for diabetic patients and those on medication for heart disorders. Audits had been revisited and had resulted in improved outcomes for the patients.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had

been reviewed by the GP. Searches on record systems for patients who had long term conditions were carried out monthly so that their condition and medications could be reviewed at regular intervals with the nurse practitioner.

### Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and information governance.

Staff received annual e-learning that included: -safeguarding, fire procedures, and basic life support and information governance awareness. Staff also had access to other e-learning training modules.

The nurse practitioner attended local practice nurse forums and attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurse practitioner met with one of the GP partners on a weekly basis to discuss any clinical cases and offer support.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (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). There were annual appraisal systems in place for all other members of staff which included personal development plans.

### Working with colleagues and other services

Incoming letters from hospitals were scanned onto patient notes and passed onto GPs for action and dealt with on a daily basis. The practice used the patient chose and book and system for referrals to hospitals. More urgent referrals were faxed and followed by letter.

The practice liaised with other healthcare professionals such as the Community Diabetic Specialist and the Community Matron. The practice also liaised with a multi-disciplinary health care team to discuss patients on their palliative care register.

### Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff.

# Are services effective?

(for example, treatment is effective)

The practice used summary care records to ensure that important information about patients could be shared between GPs at the practice. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice had several systems in place to ensure good communications between staff. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues.

## Consent to care and treatment

We spoke with the GPs about their understanding of the Mental Capacity Act 2005 and Gillick guidelines. GPs and the nurse practitioner demonstrated an awareness of the Mental Capacity Act and when best interest decisions needed to be made. However, the nurse practitioner and other staff had not received any recent training. GPs were

aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

## Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia and various lifestyle management support.

Immunisation rates were in line with the averages for the area for example the percentage of infants receiving their first vaccinations was 100% which was higher than the local average of 96.9% and the mumps, measles and rubella vaccination rate was 91.7% infants which was slightly lower than the local average of 94%.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity.

Results from the national GP patient survey (from 110 responses) also showed that 96% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 95% said the last GP they saw or spoke to was good at listening to them, which is higher than the national average.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The waiting room and reception area was small and there was the possibility of being overheard. The practice were aware of this problem and staff we spoke with advised that patients were offered a private area to discuss issues if they so wished.

### **Care planning and involvement in decisions about care and treatment**

Results from the national GP patient survey showed that 95% said the last GP they saw or spoke to was good at explaining tests and treatments and 93% said the last GP they saw or spoke to was good at involving them in decisions about their care which was higher than the national average. Ninety percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

### **Patient/carer support to cope emotionally with care and treatment**

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. Patients who had been bereaved were contacted to see if they required any additional support.

Information regarding support for carers was available in the waiting room.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice were in the process of establishing a virtual Patient Participation Group. The practice manager was proposing to e-mail those patients who wanted to join to ask for their feedback on a range of topics.

A benefit of being a small practice was that the staff knew their patients well and could address their needs. The practice sought patient feedback by a variety of other means such as utilising data from the GP national patient survey.

We saw that the practice acted on patient feedback. For example we could see that results from the GP national survey highlighted that patients could be overheard at the reception area. The practice had displayed a notice highlighting they were listening to feedback around this concern. The practice had altered the seating arrangements and we were told by staff that patients could always discuss their needs in a private area if they so wished. However, there was no information at reception advising patients that they could do this which may be helpful.

### Tackling inequity and promoting equality

The surgery had access to translation services. The building had appropriate access and facilities for disabled people. There was a hearing loop and staff could access sign language services if necessary. There was a practice information leaflet available in large print if necessary for the visually impaired.

The practice had an equal opportunities policy which was available to all staff on the practice's computer system.

### Access to the service

The practice was open between 8.30am to 6.00pm Monday to Friday. The practice operated a mixture of routine, same day and emergency appointments. Appointments could be booked up to eight weeks ahead and the appointment system allowed GPs flexibility so they could spend longer with patients if they required more time at an appointment.

In addition the practice participated in the extended hours scheme and opened once a week until 8pm to allow patients who could not attend during normal working hours access to services.

Results from the GP national Patient survey showed 84% of respondents find it easy to get through to this surgery by phone which was much higher than the local average of 61%. Patients and reception staff told us patients were always given a choice of who they wanted to see and when they wanted to attend.

### Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available in the waiting room and in the practice leaflet. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint and written apologies were given.

The practice kept a complaints log and recorded verbal as well as written complaints. The practice reviewed the complaints received on an annual basis to identify any trends in issues which would require any improvements.

# 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

Staff we spoke with were aware of the culture and values of the practice of making the patient the centre of everything they did.

Comments we received were very complimentary about the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

### Governance arrangements

The practice had practice specific policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies were regularly reviewed and in date and staff we spoke with were aware of the contents.

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

Staff meetings were held when necessary but did not have fixed agendas to discuss learning from complaints or incidents. The practice manager told us that learning points were cascaded via email to the relevant staff depending on the nature of the complaint or incident.

### Leadership, openness and transparency

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

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

Results of surveys and complaints were discussed at staff meetings but these were only held when necessary.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. In addition the practice manager was currently setting up a virtual patient participation group to gain feedback on a variety of topics.

### Management lead through learning and improvement

The practice worked well together as a team. There were systems in place to allow staff to develop for example, one member of staff told us about how their appraisal process had identified their wish to improve and gain a further qualification. This not only developed the career of the individual but also benefited the practice and its patients.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and recognised the need to address future challenges.