Dr Anita Sharma

Quality Report

Chadderton South Health Centre
Eaves Lane
Chadderton
Oldham
OL9 8RG
Tel: 0161 652 1876
Website: www.southchaddertonhealthcentre.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The practice of Dr Anita Sharma was inspected on 5 March 2015. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We rated the practice as good in respect of being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

The practice has a system in place for reporting, recording and monitoring significant events. Significant incidents and events are used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice.

The practice has systems in place to ensure best practice is followed. This is to ensure that people's care, treatment and support achieves good outcomes and is based on the best available evidence.

Information we received from patients reflected that practice staff interact with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.

Patients spoke positively in respect of accessing services at the practice. A system is in place for patients who require urgent appointments to be seen the same day.

We saw areas of outstanding practice including:

The practice patient participation group (PPG) had been active in the area of health promotion at the practice. They were very involved in helping to plan and facilitate regular health promotion events at the practice.

The practice had established links with local voluntary and third sector groups. For example the practice had established links with Age UK Oldham to promote health programmes for the recently retired. The practice had also worked closely with a local mosque to develop a health education programme.

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

Summary of findings

Importantly, the provider should:

The electronic patient records system alerted the GPs and other clinical staff when a safeguarding issue or safeguarding plan had been identified and developed for adult patients. The electronic patient records system did not however provide such alerts when a safeguarding issue or safeguarding plan had been identified and developed for children. Whilst this information was in the patients record to maximise the awareness of clinical staff the alert system should be extended to include children where safeguarding issues or a safeguarding plan have been identified or developed.

Whilst we acknowledge that the practice clinical team is relatively small and staff had a clear understanding of how to keep children and vulnerable adults safe it was not clear who the clinical lead was in respect of safeguarding at the practice. To ensure staff are clear on where they can access support regarding safeguarding matters, the practice should identify a clinical safeguarding lead and communicate who this person is to all staff.

The vast majority of prescriptions issued at the practice were computer generated. A system was in place to ensure the security of prescription forms against theft and misuse. One of the GPs was occasionally using a pre-printed prescription pad. The prescription pad had been issued to the GP in 2012 and was stored securely. It was not evident that a record was made of the serial numbers of the prescriptions on this pad. To maximise the security of prescription forms against theft and misuse the provider should ensure their prescription security checks include any pre-printed prescription pads.

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. There were sufficient staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data demonstrated patient outcomes were at or above average for the locality. 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. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand what services were 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 and Oldham Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it mainly 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.

Summary of findings

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 clinical and practice 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 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, for example in dementia and end of life care. It 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. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Where patients did not attend appointments there was a system in place to establish the reasons why and offer another flexible appointment to encourage patients to attend and discuss any concerns they may have.

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients 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. We saw good examples of joint working with midwives, health visitors and school nurses.

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

Summary of findings

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects 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. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered this population group longer appointments. Where patients did not attend appointments there was a system in place to establish the reasons why and offer another flexible appointment to encourage patients to attend and discuss any concerns they may have. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients how to access various support groups and voluntary organisations. 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). Patients experiencing poor mental health were provided with an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received eight completed CQC comment cards and spoke with 13 patients on the day of inspection and 5 members of the practice's patient participation group (PPG) prior to and during our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed CQC comment cards were very positive about the care and treatment provided by the doctors and nurses and the support provided by other members of the practice team. They said that their privacy and dignity was maintained and that they were treated with respect. The representatives of the PPG told us they met with the practice management team regularly and that their views were listened to, valued, respected and acted upon to improve the experience of patients.

We also looked at the results of the January 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

What this practice does best;

81% of respondents find it easy to get through to this surgery by phone. (Local CCG average: 70%).

94% of respondents say the last appointment they got was convenient. (Local CCG average: 91%).

81% of respondents were able to get an appointment to see or speak to someone the last time they tried (Local CCG average: 80%).

What this practice could improve;

56% of respondents usually wait 15 minutes or less after their appointment time to be seen (Local CCG average: 72%).

69% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. (Local CCG average: 81%).

46% of respondents with a preferred GP usually get to see or speak to that GP. (Local CCG average: 58%).

435 surveys sent out. 109 surveys back. 25% completion rate.

Areas for improvement

Action the service SHOULD take to improve

The electronic patient records system alerted the GPs and other clinical staff when a safeguarding issue or safeguarding plan had been identified and developed for adult patients. The electronic patient records system did not however provide such alerts when a safeguarding issue or safeguarding plan had been identified and developed for children. Whilst this information was in the patients record to maximise the awareness of clinical staff the alert system should be extended to include children where safeguarding issues or a safeguarding plan have been identified or developed.

Whilst we acknowledge that the practice clinical team is relatively small and staff had a clear understanding of how to keep children and vulnerable adults safe it was not clear who the clinical lead was in respect of safeguarding at the practice. To ensure staff are clear where they can access support regarding safeguarding matters the practice should identify a clinical safeguarding lead and communicate who this person is to all staff.

The vast majority of prescriptions issued at the practice were computer generated. A system was in place to ensure the security of prescription forms against theft and misuse. One of the GPs was occasionally using a pre-printed prescription pad. The prescription pad had been issued to the GP in 2012 and was stored securely. It was not evident that a record was made of the serial numbers of the prescriptions on this pad. To maximise the security of prescription forms against theft and misuse the provider should ensure their prescription security checks include any pre-printed prescription pads.

Summary of findings

Outstanding practice

The practice patient participation group (PPG) had been active in the area of health promotion at the practice. They were very involved in helping to plan and facilitate regular health promotion events at the practice.

The practice had established links with local voluntary and third sector groups. For example the practice had established links with Age UK Oldham to promote health programmes for the recently retired. The practice had also worked closely with a local mosque to develop a health education programme.

Dr Anita Sharma

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager). Our inspection team also included an Expert by Experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dr Anita Sharma

The practice is situated in the Chadderton area of Oldham. At the time of this inspection we were informed 3,271 patients were registered with the practice. The population experiences similar levels of income deprivation affecting children and older people than the practice average across England. There is a lower proportion of patients above 65 years of age (13.2%) than the practice average across England (16.53%). There is a higher proportion of patients under 18 years of age (15.9%) than the practice average across England (14.8%). 58 per cent of the patients have a longstanding medical condition compared to the practice average across England of 53.54%.

A wide range of medical services are provided at the practice (details of which are provided on the practice website) and in printed patient information. At the time of our inspection three GPs (one female and two male) were providing general medical services to patients registered at the practice. The GPs are supported in providing clinical services by an advanced nurse practitioner (female), a family planning nurse (female), a practice nurse (female) and a health care assistant (female). Clinical staff are supported by reception and administrative staff. The practice was in the process of recruiting a new practice manager at the time of our visit. A temporary practice manager was supporting the practice team until the newly appointed person commenced.

The practice contracts with NHS England to provide Primary Medical Services (PMS) to the patients registered with the practice.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider. The practice website provides patients with details of how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

Detailed findings

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health

and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 March 2015 and spent seven hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received eight completed CQC comment cards, spoke with 13 patients on the day of our visit and also spoke with five members of the practice's patient participation group (PPG) prior to and during our visit. We spoke with patients from various age groups and with people who had different health care needs. We also spoke with two of the GPs, the temporary practice manager, the practice nurse, the health care assistant, and two members of the practice reception/administration staff.

Good

Are services safe?

Our findings

Safe Track Record

There were clear lines of leadership and accountability in respect of how significant incidents (including mistakes) were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and NHS Oldham Clinical Commissioning Group (CCG)) to share what they knew. No concerns were raised about the safe track record of the practice. Discussions with senior staff at the practice and written records of significant events indicated they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. Learning was based on a thorough analysis and investigation of things that go wrong. All staff were encouraged to participate in learning and to improve safety as much as possible. Opportunities to learn from external safety events were identified. We spoke with clinical and non-clinical staff. They told us that the culture at the practice was fair and open and they were encouraged to report incidents and mistakes and were supported when they did so. The learning from significant events was discussed at the monthly practice meetings. We looked at records relating to how the practice team learnt from incidents and subsequently improved safety standards. The examples we looked at showed how incidents were investigated by defining the issue clearly and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again.

The practice had a system for managing safety alerts (from external agencies). These were communicated to the GPs and other relevant staff and action was taken where appropriate to do so. We saw a recent example of this relating to the safety of window blinds in areas accessed by patients. Prompt action had been taken at the practice to comply with the actions required in the safety alert.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. We discussed how safeguarding was managed at the practice and looked at the systems used to ensure patients safeguarding needs were addressed.

The electronic patient records system alerted the GPs and other clinical staff when a safeguarding issue or safeguarding plan had been identified and developed for adult patients. The electronic patient records system did not however provide such alerts when a safeguarding issue or safeguarding plan had been identified and developed for children. Whilst this information was in the patients record to maximise the awareness of clinical staff the alert system should be extended to include children where safeguarding issues or a safeguarding plan have been identified or developed.

We also saw that the practice team were communicating regularly with the safeguarding leads for children and adults at Oldham social services and the CCG when required and provided reports to them when requested to do so. Staff training records clearly demonstrated when clinical and non-clinical staff had last been provided with safeguarding training in respect of vulnerable children and adults. We saw evidence that two of the GPs, the advanced nurse practitioner, the practice nurse and the health care assistant had received updated enhanced (level 3) children's safeguarding training in November 2014.

Whilst we acknowledge that the practice clinical team is relatively small and staff had a clear understanding of how to keep children and vulnerable adults safe it was not clear who the clinical lead was in respect of safeguarding at the practice. To ensure staff are clear where they can access support regarding safeguarding matters the practice should identify a clinical safeguarding lead and communicate who this person is to all staff.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. No issues in respect of chaperoning were raised by patients we spoke with or received information from.

Medicines Management

Systems were in place for the management, secure storage and prescription of medicines within the practice.

Good

Are services safe?

Management of medicines was the responsibility of the clinical staff at the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions. It was established practice to monitor the amount of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained.

The vast majority of prescriptions issued at the practice were computer generated. A system was in place to ensure the security of prescription forms against theft and misuse. One of the GPs was occasionally using a pre-printed prescription pad. The prescription pad had been issued to the GP in 2012 and was stored securely. It was not evident that a record was made of the serial numbers of the prescriptions on this pad. To maximise the security of prescription forms against theft and misuse the provider should ensure their prescription security checks include any pre-printed prescription pads.

Cleanliness & Infection Control

We looked around the practice during our visit. Systems were in place to ensure the practice was regularly cleaned. We looked at cleaning schedule records and a risk assessment process was in place. We found the practice to be clean at the time of our visit. A system was in place for managing infection prevention and control. The health care assistant provided leadership in this area and had been provided with training to fulfil this role. Other staff had been provided with regular infection prevention and control training and this included the use of appropriate hand washing techniques. We saw that appropriate hand washing facilities (including liquid soap and disposable towels) and instructions were available throughout the practice. We saw evidence that recent checks had been undertaken to make sure measures taken to prevent the spread of potential infections were periodically risk assessed. This is important to ensure their continued effectiveness and minimise the risks associated with potential infections for patients, staff and visitors to the practice. A risk assessment and checks had been undertaken in respect of minimising the risk of legionella in 2014. Legionella is a germ found in the environment which can contaminate water systems in buildings.

We saw that practice staff were provided with suitable protective equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients.

We looked at the three consulting/treatment rooms. These rooms were clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place. The practice was registered and contracted to carry out minor surgical procedures. We looked at the treatment room used for carrying out minor surgical procedures. This room was also clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place and medical instruments used for minor surgical procedures were disposed of after single use. Unused medical instruments and dressings were stored in sealed packs. We looked at these and found all to be within the expiry date on the packs. One of the GPs took the lead in relation to minor surgical procedures and had undertaken updated training in relation to this in 2014.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste was stored safely and securely in specially designated bags before being removed by a specialist contractor. We saw records that detailed when such waste was removed.

Equipment

A record of maintenance of clinical, emergency and other equipment was in place and it was recorded when any items were repaired or replaced. We saw that all of the equipment had been regularly tested and the practice had contracts in place for personal appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration of equipment.

Staffing & Recruitment

The practice was staffed to enable the primary medical service needs of patients to be met. We were informed the practice had recently reviewed their staff mix, numbers and configuration to meet the changing and increasing demands on the services provided. This had identified the need to recruit a full time advanced nurse practitioner to

Good

Are services safe?

improve access for patients. Recruitment to this post had commenced prior to our visit. A system was in place to plan surgery times that ensured a GP was available for all the sessions.

We looked at staff recruitment practices and records. A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body, for example The General Medical Council (GMC). Also a Disclosure and Barring Service (DBS) check had been conducted for all clinicians to assess the person's suitability to work with potentially vulnerable people. Other staff who cared out chaperoning duties had a Disclosure and Barring Service (DBS) check.

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all clinical practice staff received annual basic life support training. Non-clinical staff received such training every three years. We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

The practice is housed in South Chadderton Health Centre. We looked at records that demonstrated the practice had carried out risk assessments to identify all risks associated with their premises and that they were managing these risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

Discussion with two of the GPs and the practice nurse and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw four recent examples of these relating to prescribing vitamin D, lithium monitoring, oral nutritional supplements and the prescription of silver dressings. All had been completed or identified dates when they were due to be reviewed.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. Practice meeting minutes we looked at provided details of how the actions to make improvements taken were monitored over time to ensure they were embedded and effective.

Feedback from patients we spoke with, or who provided written comments, was very positive and complimentary in respect of the quality of the care, treatment and support provided by the practice team. There was no evidence of discrimination of any sort in relation to the provision of care, treatment or support.

Effective staffing

The practice team comprised of clinical and non-clinical staff were well established and there was a very low turnover of staff.

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. We saw that yearly staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff we spoke with said they being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. The other clinical staff practice nurse were supported to attend updates to training that enabled them to maintain and enhance their professional skills.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine. All referrals were frequently tracked by one of the administrative staff to ensure patients could access appointments effectively. Patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings with other health care professionals to plan and co-ordinate the care of patients. There was also a

Good

Are services effective?

(for example, treatment is effective)

co-ordinated approach to communicating and liaising with the provider of the GP out of hour's service. In particular the practice provided detailed clinical information to the out of hour's service about patients with complex healthcare needs. Also all patient contacts with the out of hour's provider were reviewed by a GP the next working day. The practice had established and developed links with the integrated care programme in Oldham and in particular had frequent contact with the local community matron to minimise the need for patients to go to the local A+E department or be admitted to hospital. This was particularly helpful for elderly patients and those with complex health conditions who were at higher risk of being admitted to hospital.

A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response.

Information sharing

All the information needed to plan and deliver care and treatment was stored securely (electronically) but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples of this when looking at how information was shared with Oldham local authority and CCG safeguarding teams.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The January 2015 GP patient survey reflected that 69% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 81% said the last GP they saw or spoke to was good at explaining tests and treatments and 89% say the last nurse they saw or spoke to was good at explaining tests and treatments.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Where people lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with legislation. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and of supporting those who did not have the mental capacity to make a decision in relation to their care and treatment. We saw a recent example where a patient had been supported by the practice in relation to adult safeguarding issues and 'best interest' decisions.

Clinical staff spoken with 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).

Health promotion and prevention

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to quickly identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma. The practice nurse and health care assistant conducted the initial health screening assessments and made referrals to one of the GPs for further assessment as appropriate.

The practice patient participation group (PPG) had been active in the area of health promotion at the practice. They were involved in helping to plan and facilitate regular health promotion events at the practice. The purpose of such events was to maximise patient engagement with health promotion and self-care education particularly with those patient groups that are harder to reach. Recent events had included a focus on men's health (including prostate issues), women's health (including menopause issues) and cardiovascular health.

A wide range of health promotion information was available and accessible to patients particularly in the patient waiting area of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation and influenza vaccinations were provided.

Good

Are services effective?

(for example, treatment is effective)

The provision of health promotion advice was an integral part of each consultation between clinician and patient. Patients were also enabled to access appropriate health assessments and checks. A system was in place to provide health assessments and regular health checks for patients when abnormalities or long term health conditions are identified. This included sending appointments for patients to attend reviews on a regular basis. When patients did not attend this was followed up to determine the reason and provide an alternative appointment.

Patients with long term sickness were provided with fitness to work advice to aid their recovery and help them return to work.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received eight completed CQC comment cards, spoke with 13 patients on the day of our visit and also spoke with five members of the practice's patient participation group (PPG) prior to and during our visit. We spoke with people from various age groups and with people who had different health care needs. Feedback we received from patients and those who were close to them was very positive about the way staff treat people. They provided a number a number of examples how practice staff (clinical and non-clinical) went out of their way to provide re-assurance and support to them and their family. The prevailing view was that because the patient group was relatively small staff knew them well and appreciated their concerns more. Information we received from patients reflected that practice staff communicated with them well. They told us that staff at the practice treated them with respect, in a polite manner and as an individual.

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between patients, those close to them, and staff were strong, caring and supportive. Staff were observed to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation rooms. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided.

Staff we spoke with said that if they witnessed any discriminatory behaviour or where a patient's privacy and dignity was not respected they would be confident to raise the issue with the practice manager. We saw no barriers to patients accessing care and treatment at the practice. Practice staff sought to work with patients who had at times presented with behaviour that was challenging. The approach adopted at the practice was to seek to resolve the issue and keep engaging with the individual patient.

Care planning and involvement in decisions about care and treatment

The January 2015 GP patient survey reflected that 69% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 82% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon. They also told us that they were treated as individuals and provided with information in a way they could understand and this helped them make informed decisions and choices about their care and treatment. A wide range of information about various medical conditions was accessible to patients from the practice clinicians and was prominently displayed in the waiting areas.

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment the practice had taken action to address this. For example language interpreters were readily accessed (face to face or by telephone) and extended appointment times were provided to ensure this was effective.

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers. A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area. A counselling support service was also available to provide emotional support to patients following referral by a GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated to ensure that patient's needs were appropriately met.

Efforts were made to ensure patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Patients were able to access appointments with a male or female GP if preferred. Longer appointments could be made for patients such as those with long term conditions or who were carers. Home visits were provided by the GPs to patients whose illness or disability meant they could not attend an appointment at the practice. Home visits were also provided by the practice nurse to monitor long term conditions in those patients to whose illness or disability meant they could not attend the practice.

Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. Where patients did not attend such appointments there was a system in place to establish the reasons why and offer another flexible appointment to encourage patients to attend and discuss any concerns they may have.

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

Systems were in place to identify when people's needs were not being met and informed how services at the practice were developed and planned. A variety of information was used to achieve this. For example profiles of the local prevalence of particular diseases, the level of social deprivation and the age distribution of the population provided key information in planning services. Significant events analysis, individual complaints, survey results and clinical audits were also used to identify when patients needs were not being met. This information was then used to inform how services were planned and developed at the practice.

The practice had a reception area, a patient waiting area and four consultation and treatment rooms. There were also facilities to support the administrative needs of the practice.

Tackling inequity and promoting equality

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

The practice had established links with local voluntary and third sector groups. For example the practice had established links with Age UK Oldham to promote health programmes for the recently retired. The practice had also worked closely with a local mosque to develop a health education programme. The purpose of these links were to encourage and maximise access to primary medical care and treatment particularly for those patient groups who may find it difficult (for various reasons) to readily engage with such services. The practice patient participation group (PPG) had been particularly active in this area in their involvement in helping to plan and facilitate regular health promotion events at the practice.

Access to the service

We received eight completed CQC comment cards, spoke with 13 patients on the day of our visit and also spoke with five members of the practice's patient participation group (PPG) prior to and during our visit. We spoke with patients from various age groups and with people who had different health care needs. Patients we spoke with or received comments from spoke positively in respect of being able to access the service. We also looked at the results of the January 2015 GP survey. 81% of the respondents found it

Good

Are services responsive to people's needs?

(for example, to feedback?)

easy to get through to the practice by phone. 81% were able to get an appointment to see or speak to someone the last time they tried and 77% said the last GP they saw or spoke to was good at giving them enough time. 81% of respondents found the receptionists at the practice helpful. Also 94% said the last appointment they got was convenient and 71% described their experience of making an appointment as good.

The opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas and were also contained on the practice website and in the practice information leaflet readily available to patients in the reception area. Patients were able to access early morning and evening appointments. We were informed that the practice had firm plans in place to improve patient access. For example they had advertised for another nurse practitioner to join the clinical team and thereby increase the number of appointments available to patients. The practice had also recently installed a new computer system to manage patient's records that will enable the practice to participate in a rota of Saturday morning surgeries for patients in conjunction with other local GP practices.

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

GP consultations were provided in 10 minute appointments. Where patients required longer appointments these could be booked by prior arrangement. A system was in place for patients who required urgent appointments to be seen the same day.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last twelve months. In line with good practice all complaints or concerns were recorded and investigated. The complaints record detailed the nature of the complaint, the outcome of the investigation and how this was communicated to the person making the complaint.

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

There was a well-established leadership structure with clear allocation of responsibilities amongst the GPs and the practice team. The GP who is the registered provider described to us a clear value system which provided the foundations for ensuring the delivery of a high quality service to patients. The culture at the practice was one that was open and fair. Discussion with members of the practice team, patients and the patient participation group (PPG) demonstrated this perception of the practice was widely shared.

Governance arrangements

There were defined lines of responsibility and accountability for clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to challenge existing arrangements and improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve the quality of the services provided.

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

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw four recent examples of these relating to prescribing vitamin D, lithium monitoring, oral nutritional supplements and the prescription of silver dressings. All had been completed or identified dates when they were due to be reviewed.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that practice staff meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings or during the regular informal discussions that took place.

Measures were in place to maintain staff safety and wellbeing. Induction and on going training included safety topics such as the prevention of the spread of potential infections and other health and safety issues. A procedure for chaperoning patients was also in place to protect staff as well as patients.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the January 2015 GP patient survey and the last survey conducted by the practice in 2013/2014. Both surveys reflected satisfaction with the care, treatment and services provided at the practice. However where issues were identified an action plan had been implemented to address them. The key issues addressed related to waiting times, appointments, telephone consultations, and getting through to the practice on the telephone.

The practice had an active patient participation group (PPG). We spoke with five members of the PPG prior to or during our visit to the practice. They told us that when issues were identified the PPG was actively consulted to develop plans to address them. They felt their views and contributions were respected and valued. Patients were being encouraged to actively comment on the services available and developments within the practice.

The practice had gathered feedback from staff through staff meetings and informal discussions. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management and that their contributions were respected and valued. Staff told us that

Are services well-led?

Good

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

they had no difficulties accessing training appropriate to their role and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through regular training and appraisal. We saw that staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

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