St Gabriel's Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Gabriel's Medical Centre on 21 May 2015. The practice had previously been inspection in October 2013 using CQC's previous inspection methodology.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with dignity and respect.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- There was a higher than average number of children registered at the practice and the GPs visited the local Sure Start Children's Centre at least once a month to make sure needs were identified and met.

We saw an area of outstanding practice:

Summary of findings

- The practice had started to offer consultations by email for some patients as a pilot. This was in response to patients saying it was difficult to access appointments.

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

Importantly the provider must:

- Ensure that recruitment arrangements include all necessary employment checks for all staff.

Also the provider should:

- Carry out further surveys looking at appointment availability and patients' satisfaction with the appointment availability.
- Improve clinical audit cycles and formalise reviews of procedures such as joint injections so improvement can be evidenced.
- Consider increasing the number of patient participation group (PPG) members so views are more reflective of the patient population.
- Provide management support and appraisals for the practice manager.

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?

Requires improvement

The practice is rated as requires improvement 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 enough staff to keep patients safe. However a Disclosure and Barring Service (DBS) check had not been carried out for all appropriate staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet those 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. Data showed that patients rated the practice less positively than other practices in the area for some aspects of care. However, from the patients we spoke with and the CQC comments cards we reviewed, patients said they were treated with compassion, dignity and respect and they were usually involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it difficult to access appointments but we saw evidence that appointments were available, with urgent appointments available the same day. The practice had started to offer email consultations for some patients. The practice had good

Summary of findings

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.

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 their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a small virtual patient participation group (PPG) that was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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. 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. A GP had the lead role in chronic disease management and plans were in place for nurses to start this management. Longer appointments and home visits were available when needed. All these patients had 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.

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. Immunisation rates were relatively low due to the culture of the practice population, but the GPs were working with the community to make improvements. GPs told us that children and young people were treated in an age-appropriate way and that young people under the age of 16 very rarely attended the practice alone. Some 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 and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure they 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 reflected the needs for this age group. The practice was trialling email consultations for some patients.

Summary of findings

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 with a learning disability. It had carried out annual health checks for people with a learning disability and longer appointments were available.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about 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). People experiencing poor mental health had received an annual physical health check and other opportunistic checks were carried out at this time. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

During our inspection we spoke with twelve patients including a member of the virtual patient participation group (PPG). We reviewed four CQC comments cards that had been completed by patients prior to the inspection.

The patients we spoke with and comments cards we reviewed gave us positive feedback except when asked about the availability of appointments. They told us that appointments were very difficult to access and they sometimes had to wait over a week for a routine appointment. However, other feedback about the practice was very positive. They said they were very pleased with the service provided and told us receptionists were very helpful, friendly and polite. Patients said they were treated in a dignified and respectful manner by all staff.

The friends and family test showed that the majority of patients would be extremely likely to recommend the practice.

We looked at the results of the latest national GP survey. This highlighted what the practice did best:

- 95% thought the last nurse they saw or spoke to was good at giving enough time (Clinical Commissioning Group (CCG) average 93%).
- 85% thought the receptionists were helpful (CCG average 84%).
- 97% of respondents had confidence and trust in the last nurse they saw or spoke to (same as CCG average).

Less positive results were:

- 57% of respondents described their overall experience of this surgery as good (CCG average 84%).
- 49% of respondents would recommend this surgery to someone new to the area (CCG average 78%).

Areas for improvement

Action the service MUST take to improve

- The provider must ensure that recruitment arrangements include all necessary employment checks for all staff.

Action the service SHOULD take to improve

- Carry out further surveys looking at appointment availability and patients' satisfaction with the appointment availability.
- Improve clinical audit cycles and formalise reviews of procedures such as joint injections so improvement can be evidenced.
- Consider increasing the number of patient participation group (PPG) members so views are more reflective of the patient population.
- Provide management support and appraisals for the practice manager.

Outstanding practice

- The practice had started to offer consultations by email for some patients as a pilot. This was in response to patients saying it was difficult to access appointments.

St Gabriel's Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. An expert by experience is someone who uses health and social care services.

Background to St Gabriel's Medical Centre

St Gabriel's Medical Centre is located in purpose built premises in the Sedgley Park area of Prestwich. The building has two floors but all patient areas are on the ground floor. There is ramped access and electronic doors making it fully accessible to patients using wheelchairs. There is a car park for patients.

Six GPs worked at the practice; two were partners. There were four male and two female GPs. There were two practice nurses that equated to one full time equivalent staff member, and a healthcare support worker There was a practice manager, staff supervisor and reception and administration staff.

The practice was open Monday to Friday from 8.15am until 6pm, with the telephones closing between 1.30pm and 2pm. Once a month the practice closed from 1.30pm until 4pm for staff training. The telephones were diverted to the out of hours service during this time. The practice was part of the Clinical Commissioning Group (CCG) pilot where extended hours appointments were available for all patients within five practices throughout the CCG area. These appointments were available until 8pm Monday to Friday and from 8am until 6pm during the weekends.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 8300 patients were registered with the practice. There was a higher than average number of children in the practice population.

The practice was a training practice for medical students.

Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider.

Why we carried out this inspection

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. The practice had been inspected in October 2013 using previous CQC methodology.

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 May 2015. During our visit we spoke with a range of staff including GPs, a practice nurse, healthcare support worker, practice manager and reception staff. We also spoke with 12 patients and a member of the virtual patient participation group (PPG). We reviewed four CQC comments cards.

Requires improvement

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Bury Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

Discussion with senior staff at the practice and written records of significant events revealed that 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 and feedback from patients and others. We saw evidence that significant events were recorded and discussed with relevant staff.

The staff we spoke with were aware of how to report significant events, and usually reported them to the practice manager in the first instance. We saw that significant events were shared with staff during staff meetings and safety information was available for all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred. Staff told us that national patient safety alerts and significant events were regularly discussed at practice and clinical meetings There was evidence that the practice had learned from these. Staff, including receptionists and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw examples of changes to practice being put in place where recommendations had been made. These included providing additional staff support after some events. Significant events were an agenda item at staff meetings and we saw evidence of them being discussed. The discussions included areas where changes or improvements could be made.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Policies were in place that provided staff with relevant information. The practice also held information from Bury CCG about adult and children's safeguarding. This included relevant contact details and a flow chart to guide staff through the referral process.

We looked at training records which showed that staff had received relevant role specific training on safeguarding vulnerable adults and children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All the GPs had been trained to the appropriate level (level three). All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. We saw an example of a safeguarding referral that had been made and saw it had been discussed with all relevant staff at the time.

There was a chaperone policy in place. This gave instruction to follow for any staff member who was chaperoning a patient. Posters were seen in the practice informing patients they could request a chaperone during an examination. Staff had received in-house training and all the staff we spoke with were familiar with the procedure they should follow. They told us they were responsible for noting patients' records after they had acted as a chaperone. Staff who carried out chaperone duties had not had a Disclosure and Barring Service (DBS) check carried out on them.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Requires improvement

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. The emergency medicines kept in the practice were appropriate, and medicine for anaphylaxis was in each consulting room. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that the practice tightly controlled their stock of blank prescriptions. A minimal number of prescriptions were taken on home visits and the serial numbers of these were recorded as they were issued. An external pharmacist regularly attended the practice to carry out medicines reviews. They were able to provide clinicians with up to date advice and give feedback about their procedures.

A GP reviewed all repeat prescriptions before they were signed and given to patients. Patients had regular medicine reviews to ensure prescriptions were repeated only when necessary. The practice worked closely with a member of the CCG medicines management team to put in place various prescribing initiatives. This ensured the practice was prescribing in line with the latest guidance. We saw evidence that the lead GP informed other clinicians of new guidance received following Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, and this was by email.

Cleanliness and infection control

We observed the premises to be visually clean and uncluttered. We saw that liquid soap, alcohol hand rub and paper towels were available next to all hand wash basins. Sharps boxes were correctly assembled and labelled and they were attached to walls. Disposable privacy curtains were used around examination couches and these had last been changed in May 2015. There was vinyl flooring in the nurses' rooms. We saw a GP consultations room was carpeted. This was free of stains and in good condition. GPs told us they would use one of the treatment rooms for invasive procedures.

Two of the practice staff had the additional role of cleaners. The practice manager and other staff told us this arrangement worked very well as the staff were available at all times and were aware of exactly what needed to be carried out. Cleaning was completed each morning and evening. Cleaning schedules were in place with clear information of what cleaning should take place on a daily, weekly, monthly and less frequent basis. Cleaning records were kept. The practice manager carried out spot checks of the cleaning on an informal basis.

We saw the infection control policy reviewed in February 2015. All aspects of the prevention and control of infection were included in this, including staff training. Staff had received training and this included training in hand hygiene. The healthcare support worker was the lead for infection control and the practice manager was the deputy.

An infection control audit had been carried out in July 2013 by Bury Council and the local healthcare trust. A score of 98% was achieved and we saw the minor issues identified were improved on, where possible, within a short timescale. The audit had not been repeated due to a change of personnel at the CCG but the practice manager told us arrangements were being made for another audit to be carried out.

We saw that a Legionella risk assessment had been carried out (Legionella is a germ found in the environment which can contaminate water systems in buildings). A log was kept of hot and cold water temperatures and the flushing of low-use outlets. We saw this was carried out weekly and was up to date.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw the most recent tests had been carried out on 19 May 2015. We saw evidence of calibration of relevant equipment, for example weighing scales, spirometers, blood pressure measuring devices and the defibrillator. This had been carried out in June 2014.

Staffing and recruitment

The practice had a recruitment policy that had been reviewed in May 2015. This set out the procedure the practice followed when recruiting clinical and non-clinical staff. It included the necessity to request references, identification and qualifications and stated DBS checks would be completed. However, parts of the policy referred to another healthcare provider.

Requires improvement

Are services safe?

We looked at a selection of personnel files, including the most recently employed member of staff who started work in November 2013. The majority of staff had worked at the practice for several years and therefore had not provided the level of information required by the current recruitment policy when they started work. The report following our inspection of October 2013 had stated identification should be held for all staff at the practice, and the need for staff to provide proof of identity was included in the recruitment policy. Although proof of identity was not held the practice manager explained it had been provided for all staff prior to them being issued with their NHS computer access card.

DBS checks had not been carried out for reception staff who carried out chaperone duties during intimate examinations. The practice manager told us they had considered the need for DBS checks and decided that they were not required. This was because non-clinical staff were never alone with patients while chaperoning, and they were never required to look after babies or children during consultations with their parents.

A DBS check had not been carried out for the healthcare support worker and the practice manager stated this was because they had worked at the practice for several years. We also saw that the most recently recruited practice nurse, who started work in November 2013, had provided the practice with a Criminal Records Bureau (CRB) check from seven years prior to them starting work at the practice. An up to date DBS check had not been requested. The professional registration of nurses and GPs was checked every year.

Staffing levels and GP rotas were managed by the staff supervisor. They told us that holidays were booked early so rota cover could be arranged. When required locum GPs were used. The practice used a locum agency and all the required checks were carried out by the agency and provided to the practice. The practice usually used a regular locum and could confirm the checks were up to date.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A full risk assessment was carried out annually and we saw the latest assessment that had been carried out in November 2014. We saw evidence that the minor issues identified had been actioned. A fire risk assessment had been carried out in February 2013 by an external company. An action plan was in place following this and all actions were completed within a month. We saw that the next fire risk assessment had been booked for June 2015.

Staff told us that the oxygen was checked weekly to ensure it was ready for use. The automatic external defibrillator (AED) was checked daily. A record of these checks was not kept, but the healthcare support worker made arrangements to formalise them while we were at the practice. Emergency medicines were checked every month. A record of these checks was kept.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Staff had been trained in fire safety and a refresher course had been booked for 28 May 2015. Staff had completed health and safety training in 2013 and all had been issued with a copy of the health and safety manual.

The practice had oxygen and an AED on the premises. Staff told us these were checked regularly to ensure they were ready for use. Arrangements were being made to formalise these checks. Appropriate emergency medicines were available. These were kept securely and at the correct temperature. All the medicines we saw were within their expiry date. We saw that monthly checks were carried out to ensure the emergency medicines were available and in-date.

The practice had a business continuity plan in place and this had been reviewed in February 2015. The plan included information about how to manage in various circumstances such as loss of telephones, loss of utilities, GP and staff unavailability and circumstances where the building could not be used. A copy of the plan was kept at the homes of key staff as well as being available at the practice. A list of telephone numbers that may be required in an emergency was also included in the plan.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed fire alarms and emergency lighting were checked regularly. Fire extinguishers had an annual service. Fire

Requires improvement

Are services safe?

training had been provided for all staff except the most recently recruited. Refresher training had been booked for the month of our inspection to ensure all staff had received appropriate information.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. The Clinical Commissioning Group (CCG) produced protocols interpreting new guidance, for example National Institute for Health and Care Excellence (NICE) medicines management guidance. GPs told us that when new guidance was received it was disseminated to all relevant staff.

We saw evidence that when new guidance was received GPs discussed new pathways for patients. Examples included a written practice protocol for the diagnosis and management of hypertension, following new guidelines being received.

The GPs told us they all took the lead in specialist clinical areas such as diabetes, asthma and dementia. Patients with long term conditions, such as chronic obstructive pulmonary disease (COPD) or asthma, were invited for an annual review of their condition. We saw the practice was performing in line with their Quality and Outcome Framework (QOF) targets for reviewing long term conditions.

We saw that a register was kept of patients with a learning disability. The register was verified by the learning disability team once a year and an annual review of the patients took place. All but one patient with a learning disability had had a face to face annual review, and the one patient had had a telephone review.

All patients over the age of 75 had a named GP. This GP took the lead on care for the elderly. One of the practice nurses also had responsibility for patients over the age of 75.

We saw meeting minutes confirming palliative care meetings had taken place every three months. Appropriate staff attended these.

Discussion with GPs and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff conducted consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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.

We saw some evidence of the practice completing clinical audit cycles. We saw the first cycle of an audit for stroke prevention in atrial fibrillation, although the second cycle had not been completed at the time of our inspection so results were unknown. Fact finding audits were regularly completed and we saw a recent audit for A&E attendance where some inappropriate attendance was highlighted. In addition GPs undertook regular reviews of their practice, for example joint injections and minor surgery. These did not take the form of formal audits.

The practice worked closely with the CCG medicines management team. We saw that a number of prescribing initiatives had been undertaken. These included reviewing patients receiving a medicine for stomach complaints to ensure the latest prescribing guidelines were being followed. GPs checked all prescriptions being issued and reception staff did not re-authorise any prescriptions.

One of the GPs took responsibility for carrying out reviews for patients with long term conditions. They were in the process of reconfiguring the management of chronic diseases. They hoped to streamline the process so patients with multiple conditions did not need to be seen on various occasions.

We saw evidence of the QOF being regularly discussed at practice meetings. The status of annual health checks, such

as for COPD and asthma, were discussed during these meetings. When patients did not attend for their checks they were contacted by telephone to arrange another appointment.

GPs attended Clinical Commissioning Group (CCG) GP meetings to keep up to date with any changes in the area. Nurses also attended similar meetings. Information was then disseminated to other relevant staff.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and at least two 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The practice manager kept a record of the training completed for each staff member. We saw that mandatory training was up to date for most staff. The practice manager monitored training via their computer and arranged updated training when it was required. There was protected learning time one afternoon each month when the practice was closed. Mandatory training, along with some staff meetings, took place during this half day. Staff were able to request additional training appropriate to their role.

There was an induction programme in place for all new staff. The formal documentation was specific to the practice but the practice manager told us all staff received induction training relevant to their role when they started work. New staff also had a mentor to support them. Staff had a personal development plan in place.

Staff had an annual appraisal with their line manager and we saw these were up to date. The practice manager carried out appraisals with staff, and a GP was also involved in the appraisals of the practice nurses and healthcare assistant. However, appraisals did not take place for the practice manager.

The staff we spoke with told us they felt well supported at work. They said they were able to approach the practice manager with any issues they had. One staff member said they were unsure about whether they received appropriate clinical supervision. However, we saw that this was in place and was reviewed by a GP.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. Most hospital correspondence was received electronically and it was reviewed by a GP prior to being filed.

Community nurses used to work in the same building as the practice and they were invited to relevant practice meetings. We saw evidence of them attending a practice meeting during the month of our inspection. The community nurses had moved to a nearby building. We saw that the GPs recognised that regular liaison was required so they made links with the service and ensured they met regularly for updates. A heath visitor usually attended the practice each week to speak with a GP about any ongoing issues or new concerns.

The practice worked with the CCG and had regular multi-disciplinary team meetings. There had been a local project to identify carers in the community. They were then coded so they were identifiable and support could be offered. Palliative care meetings with GPs and district nurses took place every three months with a GP from the practice chairing these. Health visitors attended the practice every week to run the baby clinic.

The practice was in a predominantly Jewish area and the majority of patients were of the Jewish faith. They had links with the Jewish federation which benefited the local population. The practice also had good links with local schools and the pharmacy which was based in the same building as the practice.

Patients were able to access extended hours appointments at five practices in the CCG area. These pre-bookable

Good

Are services effective?

(for example, treatment is effective)

appointments were available early mornings, late evenings and at weekends. The practice GPs were involved in the delivery of this care and the extended hours practices had access to most of the computer systems necessary.

The 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. They told us referrals were made in a timely manner.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Information about out of hours consultations was received each morning and the walk in centre also sent information to the practice daily. The A&E department informed the practice electronically of patients who had attended. Administration staff actioned the reports when they arrived and passed them to the GPs who decided if any further contact with the patient or further action was needed. The administration team then recoded details if this was required.

All the electronic information needed to plan and deliver care and treatment was stored securely 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. Electronic patient records were also available for practices involved in the local extended hours scheme. This meant that if a patient made an appointment to see a GP at one of the five practices in the scheme their records were available.

Where a patient was receiving end of life care this was communicated to the out of hours provider so they had the most recent patient information. There was a new system in place when a do not attempt cardio pulmonary resuscitation order was in place. This was to ensure the ambulance service were aware of the directive.

Consent to care and treatment

The practice had a consent protocol in place that had been reviewed in January 2015. This had information about different types of consent and included examples of forms to complete where written consent was required. The protocol included guidance about the mental capacity of patients and the Gillick competencies. Gillick competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination 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 CQC comments cards we reviewed did not highlight any issues with consent.

The latest national GP patient survey reflected that 73% of respondents said the GP was good at explaining tests or treatments to them (CCG average 83%), and 76% said the same of the practice nurse (CCG average 76%). Also 65% of respondents said the GP was good at involving them in decisions about their care (CCG average 76%), with 66% saying the same of the practice nurse (CCG average 66%).

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. We saw that the practice had various consent forms that were completed appropriately. Most clinicians told us that where appropriate they would assess the capacity of patients and take a best interest approach where needed. They said they would record this. Although clinicians understood the Gillick competencies they said it was extremely rare for a young person under the age of 16 to attend the practice alone and they tried to discourage this. However, young people under the age of 16 were able to make appointments and clinicians assessed their understanding when they attended.

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms, including a health questionnaire. There was no protocol in place regarding new patient checks. We spoke with a nurse who told us they carried out a health check if they saw a new patient, although they were unsure if this was expected of them.

Good

Are services effective?

(for example, treatment is effective)

NHS Health Checks for patients aged over 40 or over 75 were being carried out, usually by a practice nurse. These were carried out on an opportunistic basis with some patients being targeted with a letter or text message. Patients over the age of 75 had a named GP.

The practice had a system in place to ensure patients eligible for the flu vaccine received these. The practice held a dedicated flu vaccination clinic, and opened late at night. Posters had been displayed, messages were printed on prescriptions and the availability of the flu vaccine had been advertised on the website. This had not been as effective as hoped so the practice was looking at other ways of capturing patients who would benefit from a flu vaccine. A nurse strategy meeting had been held to discuss how they would manage the vaccinations during the next flu season.

The practice carried out a lower than average level of child immunisations. GPs explained that some parents did not want their children immunising due to their culture. They were working in the community and via the synagogues to try to increase the vaccination levels. GPs telephoned patients and on occasions visited them to explain the benefits of vaccinations.

A member of the administrative team managed the recall system for cervical smears and annual health checks. Patients who did not attend received a telephone call to encourage them to make an appointment. A health trainer attended the practice weekly to give healthy living advice, and patients could self-refer for this service. Travel vaccinations and a smoking cessation service was also available at the practice.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The patient survey showed that 69% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 85%) and 79% thought their GP was good at listening to them (CCG average 89%). The figures when asked the same about the nurse were 79% (CCG average 78%) and 78% (CCG average 79%). The survey showed that 85% of patients found the receptionists helpful (the same as the CCG average), 75% thought the GP gave them enough time (CCG average 88%), and 83% thought the same of the nurse (CCG average 80%).

The patients we spoke with gave us mainly positive comments about the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. We reviewed four CQC patient comments cards, and these gave us no concerns about the respect, dignity and compassion provided by the practice.

The majority of patients told us they had enough privacy at the reception desk. There was an electronic check in facility so patients did not have to queue at the desk if attending for an appointment. There was also a private room available if a patient requested a more private conversation. Patients told us they were able to request to see a GP of a specific gender, as the practice had four male GPs and two female GPs.

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

Care planning and involvement in decisions about care and treatment

The latest GP patient survey information showed 65% of patients felt the GP was involving them in decisions about their care (CCG average 76%), with 66% saying the same of the nurse (CCG average 86%). The survey showed that 65% of patients thought the GP was good at explaining tests and treatment (CCG average 82%) and 76% said the same of the nurse (CCG average 76%). The majority of the patients we spoke with told us the GPs and practice nurses explained tests and treatment to them and they felt they were listened to. Most said they were given options about their treatment where this was available. The CQC comments cards we reviewed showed no concerns being highlighted about people's involvement in their care planning.

Staff told us that translation services were available for patients who did not have English as a first language. Face to face or telephone interpreters were accessed. The website could also be translated into different languages.

We saw that a range of information about various medical conditions was available in the reception area. Information about other services that were available in the area was also displayed.

Patient/carer support to cope emotionally with care and treatment

Counselling services were not available at the practice but a local counselling charity operated in the area. Patients could self-refer to these services or be referred by their GP. The Jewish community also had a local private counselling provision. Bereavement counselling was available through these services. The health trainer at the practice was able to offer emotional support and suggest a referral to another service if appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. There was a low rate of chronic smoking among the practice population and therefore a lower rate than expected of chronic obstructive pulmonary disease (COPD).

GPs took a lead role for specific conditions. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. The GP lead was in the process of reconfiguring the service so that patients with multiple conditions did not have to attend for more than one review. When patients with mental health needs attended for their annual review other opportunistic checks, such as blood pressure or flu vaccinations, were carried out. The lead practice nurse carried out annual checks for patients with a learning disability. Medicine reviews were arranged at appropriate intervals for patients who required regular medicines.

Multi-disciplinary meetings took place every quarter and the minutes and action plans following these meetings were circulated to all relevant staff. Gold standard framework meetings were also held between services involved in the end of life care of patients. These meetings were minuted. The practice had improved access to GP telephone triage calls in an attempt to reduce inappropriate A&E attendances. The impact of this had not yet been assessed. When a patient was discharged from hospital a GP reviewed their needs to reduce the possibility of re-admittance.

Due to the location of the practice community based services for patients were provided by three different Clinical Commissioning Groups (CCGs). This caused difficulty with access. GPs liaised via Bury CCG to try to formalise and unify the provision of services for all their patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They told us that most patients spoke English as their first language but they had access to an interpreter service if required.

The practice did not have any homeless patients. They told us that although an address is usually required for a patient to register they would seek advice from the CCG about how to register a homeless person should the need arise. There were no travellers in the immediate vicinity.

All housebound patients were coded on the computer system so they could be easily identified. Home visits were made when required. Patients receiving palliative care received more regular formal reviews and were visited at home whenever this was required. The practice nurses and healthcare support worker also carried out home visits. District nurses carried out visits only for patients who had been referred to them.

There was a larger than average number of children registered with the practice and GPs told us this was due to a high number of large families in the area. In order to capture the needs of children one of the GPs visited the Sure Start Children's Centre in the area at least once a month.

The practice had two floors but all patient areas were on the ground floor. It was fully accessible for patients using a disability or with a pushchair. There was parking available close to the entrance and there was an accessible toilet.

Access to the service

The practice was open from Monday to Friday 8.15am until 6pm. The telephones were not answered between 1.30pm and 2pm. The practice was closed for one Thursday afternoon each month between 1.30pm and 4pm for staff training. The out of hours service was available when the practice was closed. In addition the practice was part of a CCG wide pilot where seven day GP access was available. This meant all patients could pre-book appointments until 8pm on weekdays and between 8am and 6pm at weekends. These appointments were within four hub sites in the CCG area. GPs from the practice provided regular cover for this service. Although St Gabriel's Medical Centre was not one of the practices where patients could attend, their patients could attend any of the available hubs. Patients' records were available for these consultations so the GPs had all available information.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Every Wednesday morning an open surgery was held. This meant that any patient coming to the practice before 10.30am would be seen by a GP that morning.

The practice explained the appointments system to us. Appointments for GPs could be booked on-line, by telephone or in person. Appointments for the following week were released each Wednesday afternoon at 2pm. Patients told us the telephones were extremely busy at this time and they found it difficult to access these pre-bookable appointments. Telephone appointments with a GP could also be pre-booked.

Urgent on the day appointments were available and a GP triage service was available each day to assess the need of urgent appointments. The practice had also started to offer email consultations to some patients as a trial. They had started to give text message appointment reminders to patients as a way to reduce the number of patients who did not attend.

We spoke with 12 patients including a member of the PPG. Most patients told us they thought it was very difficult to access appointments, with some saying this was the only thing about the practice that was not positive. Four patients had completed CQC comments cards and one of these also stated it was difficult to access an appointment. We checked the availability of appointments at 10.05am on the day of our inspection. We saw that emergency appointments were available for that day, and the next available pre-bookable appointments was in four working days' time. The patient participation group were monitoring the availability of appointments and they felt the current system was working.

The responses to the most recent GP patient survey showed lower than average responses to questions relating to appointments. Although 88% of patients said their last appointment was convenient (CCG average 92%, 52% said they found it easy to get through to the practice on the telephone (CCG average 65%). In addition 45% of patients rated their experience of making an appointment as good (CCG average 70%) and 64% of patients said they were satisfied with the opening hours (CCG average 76%).

The practice had carried out their own patient survey towards the end of 2014 and these responses were more positive. We saw that 108 responses had been received from the national survey compared 479 from the practice's own survey. In the practice survey 77% of respondents said they were satisfied with the current opening hours. We saw that 89% of respondents said they would use the extended hours service currently being piloted within the CCG.

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. The practice manager was responsible for managing complaints and the process was overseen by a GP. We saw there was a complaints flow chart for staff to follow if they received a complaint.

We saw the summary of complaints made in the period April 2014 to March 2015. All had been appropriately investigated and where learning needs had been identified this had been recorded. GPs told us that they tried to meet with or telephone patients if a complaint had been made.

We saw that if a complaint had been made about an individual staff member this was shared with them on a one to one basis. We saw evidence that if learning needs had been identified for the team this was fed back at practice meetings.

There was a leaflet available to inform patients how to make a complaint, and information was also included on the practice leaflet and website. Patients told us they would feel comfortable making a complaint if they needed to and that they would approach individual staff or the practice manager.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a statement of purpose which promoted a caring and responsive service with good outcomes for patients. All staff we spoke with demonstrated this target. There were no recent official practice values but GPs told us they led by example to be caring, conscientious, concerned and efficient. Staff knew their responsibilities towards patients and other practice staff. GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs were committed to providing a high quality service to patients in a fair an open manner. The GPs had a clear vision to deliver high quality care and promote good outcomes for patients.

The practice was keen to improve patient care and took on initiatives to improve quality that were led by the CCG. They were also a training practice and were fully aware of their requirement in relation to this.

Governance arrangements

Most areas of responsibility and accountability for the clinical and non-clinical staff were defined. The practice held regular staff practice meetings. GPs and nurses also had separate meetings. There was no set agenda for the meetings; current issues or topics were discussed.

We saw meeting minutes from several meetings. These contained a lot of information about what had been discussed. They provided evidence that all relevant issues were discussed or disseminated to appropriate staff. Staff told us they thought communication within the practice was usually good and the meeting minutes provided evidence of this.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. 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. We saw evidence that there was good sharing of the latest guidelines and protocols and necessary changes to clinical practice were also discussed.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a lead partner and each GP had an area of responsibility. GPs told us they were keen on succession planning, although the current GP team was relatively young. One of the partners was leaving the practice but plans had been made for them to have a surgery on one day a week until a new clinician was appointed.

Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that regular meetings were held for all staff members. This included the administrative team, who met weekly. The meetings were used to disseminate any relevant information to staff and give them the opportunity to ask any questions.

Seeking and acting on feedback from patients, public and staff

The practice had a virtual patient participation group (PPG). There were seven members and they were managed by the practice manager. The practice manager told us members of the PPG were recruited via the website and when the group started information was displayed in the waiting room. They said they struggled to get members under 20 years old. However, a notice on the practice website stated they currently had sufficient members of the PPG.

The PPG had agreed to be contacted twice a year to comment on action plans, strategies and to assist with the patient survey. We saw they had been asked for their comments on the questions to be asked in the practice's patient survey.

The practice carried out their most recent patient survey during six weeks in October and November 2014. They

Are services well-led?

Good

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

received 479 responses; 6% of the practice population. The survey asked patients about their satisfaction with the opening times, then concentrated on seeing if patients knew about aspects of the practice such as telephone appointments and on-line services. The PPG were asked for their opinion of the practice.

The practice encouraged patients to take part in the NHS Friends and Family Test, and they were able to do this either on-line or at the practice. We saw the results to date were positive.

Management lead through learning and improvement

Staff told us they thought they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. Protected learning time was available each month. Most staff told us they were supported in their personal development.

The nurses were able to obtain clinical advice from any of the GPs at the practice, and they supported them in their appraisals and in their continuing professional development (CPD). GPs told us the lead nurse also helped with the CPD of the other practice nurse.

All staff except the practice manager had an annual appraisal with their line manager. We saw staff had a personal development plan in place and their on-going learning had been discussed.

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), indicated that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

The practice was a training practice for medical students. We saw that feedback from students and the university was frequently sought and we saw evidence that the practice was rated highly as a training practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not operate robust recruitment procedures to ensure they only employed fit and proper staff. This was in breach of regulation 19(1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Disclosure and Barring Service (DBS) checks had not been sought for all appropriate staff members. Regulation 19(1)(a)(2)