The Uplands Medical Practice

Quality Report

Bury New Road
Whitefield
Manchester
M45 8GH
Tel: 0161 766 8221
Website: www.theuplandsmp.nhs.uk

Date of inspection visit: 1 May 2015
Date of publication: 25/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Uplands Medical Practice on 1 May 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, effective, caring, responsive and well-led services. 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. Significant events were investigated and changes to practice made where necessary.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an emergency appointment but routine appointments were more difficult to access.
- 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 were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- The provider should make changes to the way significant events are recorded so it is clear who is responsible for implementing any actions required, and a timescale for implementing actions is given.

Summary of findings

- The provider should look at increasing the number of clinical audits carried out, making sure audit cycles are completed so any improvements can be evidenced.
- The provider should consider introducing clinical protocols to link their practices with National Institute for Health and Care Excellence (NICE) guidelines.
- The provider should have a formal appraisal meeting with all staff.
- The provider should carry out Disclosure and Barring Service (DBS) checks for all staff who carry out chaperone duties.

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 enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. 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. Staff had personal development plans but formal appraisals had not taken place during the previous 12 months. These had now been booked for all staff and staff felt well supported at work. 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 higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. 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 it was sometimes difficult to make a routine appointment but they could be seen in an emergency. We saw evidence of good appointment availability. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

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. The patient participation group (PPG) was active. Staff had received inductions and attended staff meetings and events. Although appraisals had not taken place in the preceding year staff were well-supported and plans were in place for appraisal meetings to be completed during 2015.

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. All these patients had a structured annual review to check that their health and medicine needs were being met. There were plans in place so that patients with more than one long term condition could have them all reviewed during one appointment. For those people with the most complex needs, the 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 and the practice was aware of other healthcare professionals involved in patients' care. 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 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 these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as

Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. Early morning appointments were available. The practice was also part of a pilot scheme funded by the Prime Minister's Challenge Fund, where appointments at nearby practices were available seven days a week.

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 those with a learning disability. It had carried out annual health checks for people with a learning disability and all except one of these had been during a face to face appointment, with one being carried out by telephone.

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). Patient experiencing poor mental health received 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.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients including a member of the patient participation group (PPG). We reviewed 24 CQC comments cards.

The patients we spoke with told us they could usually access emergency appointments but routine appointments were more difficult to make. They said the ease of getting through on the telephone varied but it was usually busy when the lines opened in the morning. it could be difficult to get through to the practice by telephone. Patients told us staff at the practice were friendly, and they were able to choose the gender of the GP they saw. They told us staff were very helpful and were good at explaining things to them. They also said they thought they received a high standard of service.

The CQC comments cards were also positive. Patients commented that they were treated in a respectful way by caring staff. Two of the 24 cards commented that appointments could be difficult to access and one said getting through on the telephone was a problem.

We also looked at the results of the latest national GP survey. The results showed:

- 95% thought the last GP they saw or spoke to was good at giving enough time (CCG average 88%).
- 92% thought the last nurse they saw or spoke to was good at treating them with care and concern (CCG average 78%).
- 93% thought the last GP they saw or spoke to was good at listening (CCG average 90%).
- 85% thought the receptionists were helpful (figure the same as the CCG average).

Less positive results were:

- 48% found the experience of making an appointment good (CCG average 70%).
- 36% found it easy to get through to the practice by telephone (CCG average 68%).

Areas for improvement

Action the service SHOULD take to improve

- The provider should make changes to the way significant events are recorded so it is clear who is responsible implementing any actions, and a timescale for implementing actions is given.
- The provider should look at increasing the number of clinical audits carried out, making sure audit cycles are completed so any improvements can be evidenced.
- The provider should consider introducing clinical protocols to link their practices with National Institute for Health and Care Excellence (NICE) guidelines.
- The provider should have a formal appraisal meeting with all staff.
- The provider should carry out Disclosure and Barring Service (DBS) checks for all staff who carry out chaperone duties.

The Uplands Medical Practice

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 The Uplands Medical Practice

The Uplands Medical Practice is located in purpose built premises in the centre of Whitefield. The building is single storey and fully accessible to patients using wheelchairs. There is a car park for patients.

Seven GPs worked at the practice; six were partners and one a locum. Four GPs were female and three male. There was a practice nurse and a healthcare support worker, and the practice was in the process of recruiting another nurse. There was a practice manager, assistant practice manager and reception and administration staff.

The normal opening hours were 8am until 6.30pm Monday to Friday. The practice was also signed up to extended hours, with appointments available from 7.10am until 8am. The latest appointment each day was 6pm. In addition, the practice was part of a pilot funded by the Prime Minister's Challenge Fund. Patients were able to access appointments at five locations in the Bury area between 6.30pm and 8pm Monday to Friday, and from 8am until 6pm at weekends.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 8716 patients were registered with the practice.

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

We found that since the practice had registered with the CQC a new partner had joined. They were in the process of adding this partner to their registration.

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.

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 1 May 2015. During our visit we spoke with a range of staff, including GPs, the practice nurse, the health care support worker, managers and reception staff. We spoke with six patients, including a member of the patient participation group (PPG). We reviewed 24 CQC comments cards where patients shared their views and experiences of the service.

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 such as NHS England and Bury Cnical 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. They were an agenda item at the meetings between the partners and action was decided at this time. However, the information that was recorded was brief and there was no record of who was responsible for ensuring actions were taken or the date actions should be completed by.

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 and safety information was available for all staff.

The lead GP received medicine alerts. They summarised action to be taken and circulated to all relevant staff. They kept a folder of all alerts, including from the National Institute of Health and Care Excellence (NICE), with evidence of the action taken following receipt.

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, administrators 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 training where. We also saw an example of systems being put in place following a significant event occurring. This had been discussed at a practice meeting and all staff were aware of the new system that was in place.

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 the Bury CCG adult and children's safeguarding contact and information pack. 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. They were also the lead for Bury CCG and received regular updates. All the GPs had been trained to the appropriate level (level three). The practice manager was the deputy lead in safeguarding. 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 that safeguarding was an agenda item at staff meetings. If a child did not attend a pre-booked appointment this was followed up by telephone. The safeguarding lead was consulted if there were any concerns. We saw that data was kept of children at risk or where there was any cause for concern. The data included if child protection services were involved, or if there were

concerns about a member of a household where a child lived. There was information in the waiting room about young women travelling to Syria so people could be made aware of warning signals.

There was a chaperone policy in place. This gave instruction to follow for any staff member who was chaperoning a patient. The practice manager told us GPs first asked a nurse or the healthcare support worker if a chaperone was required. However, all staff had received in-house training and chaperoned when required. The staff we spoke with confirmed they had received training and 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.

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. The temperature of the fridges used to store medicines and vaccinations were checked daily and a log book completed. The fridges were not hardwired. One had a notice on the plug alerting staff it should not be unplugged but the second fridge had no alert in place.

Processes were in place to check medicines were within their expiry date and suitable for use. The medicines kept in doctors' bags were appropriate. 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. Prescription pads were kept in a locked cupboard and the serial numbers of blank prescriptions were recorded when they were taken from the cupboard. 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 repeat prescriptions before they were signed and given to patients. Patients had regular medicine reviews to ensure prescriptions were repeated only when necessary.

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. Some were attached to a wall and others were freestanding away from patient access. Disposable privacy curtains were used around examination couches and these had last been changed in February 2015. There was vinyl flooring to all consultation rooms.

Cleaners attended the practice twice a day. The cleaning company was employed by the building managers and not directly by the practice. Cleaning schedules were in place with details of what cleaning should take place on a daily, weekly, monthly and less frequent basis. and cleaning records were kept. The practice manager carried out spot checks of the cleaning on an informal basis. They were able to contact the cleaning manager if there were any concerns, but they said the standard of cleaning had improved since this company took over approximately five months earlier. The cleaning manager attended regularly and carried out their own checks. We saw that an infection control audit had been carried out in 2014 and all actions that could be dealt with had been completed. It had been noticed that some hand wash basins had overflows and they were cleaned appropriately to minimise the risk of infection.

We saw the infection control policy dated December 2014. This was a short policy that included information about training in infection prevention and control. We saw that all staff had received training earlier in 2015. The practice nurse carried out training for new staff.

We saw that the building managers had responsibility for carrying out Legionella risk assessments and checks. (Legionella is a germ found in the environment which can contaminate water systems in buildings). The practice manager was aware of these checks being carried out.

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 equipment such a spirometers, nebulisers and baby scales had been calibrated in March 2015. A schedule of testing was in place.

Good

Are services safe?

The practice had an automatic external defibrillator (AED) that staff checked regularly to ensure it was ready for use. The checks were not recorded. However, during our inspection a formal record was put in place so there would be evidence of all future checks. Oxygen was kept at the practice and we saw evidence that this was checked weekly.

Staffing and recruitment.

The practice had a recruitment policy that had been reviewed in April 2015. This set out the procedure the practice followed when recruiting clinical and non-clinical staff. This overarching policy did not include the need to check the identity of new staff and ensure a full work history was provided. It also did not mention when a Disclosure and Barring Service (DBS) check should be obtained. However, other policies and procedures were in place covering all other aspects of recruitment, including the need to check clinicians were registered with the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC). We saw the practice had a series of templates in use to guide them through the recruitment process and ensure all relevant checks had taken place.

We looked at a selection of personnel files, including a recently employed member of staff and a staff member part way through the recruitment stage. The personnel files were extremely well organised and contained all relevant information for each staff member. This included a full work history, evidence of identity, interview records, references and for staff recruited in the previous two years DBS checks. Relevant checks with GMC or NMC were also kept. The practice manager told us that a decision had been made two years ago for all new staff to have a DBS check. However, some administrative staff who had been at the practice longer than this carried out chaperone duties but had not had a DBS check. The practice manager told us they would arrange for the checks to be carried out and we saw evidence during our inspection of them starting to gather the information for this.

The practice had a permanent locum working there. They also used locum GPs on an ad hoc basis if required. We saw they used a locum agency who sent the practice required information about the locum GPs prior to them working there.

Staffing was discussed at the monthly practice meetings and annual leave was openly discussed. We saw that peak holiday times were discussed several months in advance so any staffing issues could be dealt with. The clinical rota was arranged by the senior receptionist and a GP. Although each GP had set days off they were flexible and usually able to cover the short term sickness of colleagues. The practice manager told us that the team worked very well together and were flexible around their working hours when required. All the staff we spoke with confirmed this and said they had the option of being paid for additional hours or taking the time back in lieu.

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. The practice manager and assistant practice manager carried out an informal daily check of the corridors and fire exits. A fire risk assessment was carried out by the property managers and no major issues had been identified.

We saw that the oxygen was checked weekly to ensure it was ready for use. A record was kept of this. Checks of the AED were said to be carried out but not recorded. Formal procedures were put in place during our inspection. 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 and fire awareness. Fire warden training had also been provided.

The practice had oxygen and an automatic external defibrillator (AED) on the premises. These were checked weekly to ensure they were ready for use. 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.

A disaster recovery policy was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also

Good

Are services safe?

contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. A copy of the plan was kept at the home of the practice manager, as well as electronically and on the practice premises. On-call managers held information about dealing with major incidents and a protocol was in place so an incident director and chief incident officer could be identified.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed fire alarms, emergency lighting and evacuation routes were checked regularly. Fire extinguishers had an annual service. All staff had been trained in fire safety and there were appointed fire wardens.

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. This was given to the lead GP who disseminated it to appropriate staff. GPs told us they practice did not have formal clinical protocols in place to follow for their treatment of disease or disorder. This meant that although NICE guidance was followed it was not linked directly with the procedures they carried out. The practice nurses had some protocols to follow for their chronic disease management.

The GPs told us they all took the lead in specialist clinical areas such as dementia and asthma. Patients with long term conditions, such as chronic obstructive pulmonary disease (COPD) or asthma, were invited for an annual review of their condition. The practice nurses usually carried out these reviews. At the time of our inspection they were unable to carry out a review for some multiple conditions, such as chronic heart disease and COPD, due to the nurse specialities. However, the practice hoped they would be able to offer more joint reviews when a new nurse was recruited in the near future. We saw the practice was performing in line with their Quality and Outcome Framework (QOF) targets for reviewing long term conditions.

All patients with long term conditions had a risk stratification plan in place. Nursing home patients also had care plans in place and we saw the practice had reached its targets for avoidance of unplanned hospital admission.

Clinicians had received training in read coding so patients with certain conditions were easily identifiable. 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. Some patients over the age of 75 had had a health check but these had decreased due to staffing issues. It was hoped they would be put back in place when clinical staff were recruited.

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

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 evidence of the practice completing clinical audit cycles. An audit cycle had been completed on the prescribing of Domperidone. We also saw an anti-coagulant audit had been completed and the practice were in the process of repeating this. Other audits had been completed, often by trainee doctors, but these had not been repeated to see if improvements to treatment or prescribing had improved. Action plans had been put in place following single cycle audits and we saw these were being worked through. For example, an audit to identify patients potentially suffering from dementia had been carried out so appropriate treatment could be put in place and community support identified for their carers.

Patients who were prescribed anti-depressants were only given a prescription for a maximum of three months. GPs checked all prescription requests to ensure each patient had had an annual review of their medicines. Prescriptions

Good

Are services effective?

(for example, treatment is effective)

were only authorised for 12 months and GPs tied these reviews in with the chronic disease management reviews where appropriate. Each clinician carried out approximately five medicine reviews each month. Repeat prescriptions could be ordered on-line. The lead GP told us the pharmacist who specialised in anti-coagulants was going to identify patients with more than 10 medicines and carry out separate reviews to ensure their medicines were appropriate.

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 all had been revalidated or had a date for revalidation. (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 in addition to mandatory training additional training appropriate to the role of the staff member had been arranged. The practice manager monitored training via their computer and arranged updated training when it was required. Staff were able to request additional training appropriate to their role. We saw that two reception staff were completing a phlebotomy course so they could provide clinical back up to the healthcare support worker.

There was an induction programme in place for all new staff. This was role-specific and a timetable was in place for each new staff member to show when aspects of their induction had been completed. Staff had a personal development plan in place.

Although it was usual for staff to have an annual appraisal with their line manager this had not occurred in the previous 12 months due to staffing issues. The GPs and managers had continued to support staff throughout this time and staff told us they felt well-supported at work. They said they could approach the GPs or practice manager at any time. We saw that all staff had a date booked in for an appraisal in the couple of months following our inspection.

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. The GPs told us they reviewed them, took any appropriate action and ensured their patient records were up to date.

The practice nurses did not work closely with the district nurses although they liaised with them to try to access the best care for their patients. The district nurses visited the practice until approximately a year ago. They said that district nurses visited housebound patients for example to administer the winter flu vaccination. However, they would not then give the vaccination to the partners or carers of housebound patients, who had to attend the practice. They thought that these difficulties would be resolved when they recruited an extra nurse.

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.

Good

Are services effective?

(for example, treatment is effective)

The practice worked with two other practices within the CCG area to provide care for patients in nursing or residential homes. They provided care on a rota basis, but liaised with the practices where continuity of care was beneficial. Health trainers attended the practice each week to give lifestyle advice to patients.

Information was kept on patient records when other professionals were involved in the care of children. This meant that if for example a child was seeing a paediatrician the GP could liaise with the other healthcare professional to decide the best outcomes.

Patients were able to access extended hours appointments at five practices in the CCG area. These pre-bookable 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 but this could take longer than a day. 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

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 85% of respondents said the GP was good at explaining tests or treatments to them (CCG average 82%), and 88% said the same of the practice nurse (CCG average 76%). Also 81% of respondents said the GP was good at involving them in decisions about their care (CCG average 76%), with 87% saying the same of the practice nurse (CCG average 86%).

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. There was a consent protocol that gave guidance to staff. Training in the Mental Capacity Act 2005 had been provided for clinicians. Clinicians were also up to date with information on Deprivation of Liberty Safeguards (DoLS).

The clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. Following a significant event the practice had ensured all staff were fully aware of consent guidance including Gillick competencies. GPs also told us how they

Good

Are services effective?

(for example, treatment is effective)

would obtain consent for patients who had, for example, a learning disability. They were aware of who to involve in making the decision and the circumstances where a mental capacity assessment was necessary.

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms then were offered a new patient appointment with the nurse. Although this was not obligatory it was strongly encouraged and patients were contacted by telephone if they did not make an appointment. Information such as the patient's height, weight, smoking and alcohol consumption status and family history usually were discussed and relevant information recorded. Advice about lifestyle was given and if required an appointment with the GP was arranged.

Patients aged 40 and over were invited for a NHS health screening appointment. This had been managed by the healthcare support worker and the take up rate was above the national average. The practice had not been able to offer as many over 75 health checks but we saw 99.85% of over 75s had a named GP and 25% had had a health check. There were plans in place to reintroduce and increase these.

The patients with the highest risk of being admitted to hospital had a care plan in place. One of the GPs managed and reviewed these. GPs routinely reviewed patients living in residential or nursing homes. They also reviewed patients who had been admitted to hospital where appropriate to try to avoid further admissions.

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. There were looking at the possibility of holding a Saturday clinic during the next vaccination programme but there were parking difficulties in the area that were worse on Saturdays. The take-up of the flu vaccination was monitored and patients who had not attended were contacted by telephone.

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. The practice no longer offered a smoking cessation service although staff were trained if needed. They told us the demand had been low and the service was offered at several pharmacies locally.

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 86% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 85%) and 93% thought their GP was good at listening to them (CCG average 90%). The figures when asked the same about the nurse were 92% (CCG average 78%) and 88% (CCG average 79%). The survey showed that 85% of patients found the receptionists helpful (the same as the CCG average, 95% thought the GP gave them enough time (CCG average 88%), and 91% thought the same of the nurse (CCG average 80%).

The patient satisfaction survey carried out by the practice gave positive results. Satisfaction was 95% or over for staff ability to listen, staff showing respect, warmth of greeting and showing concern to the patient.

The patients we spoke with gave us positive comments about the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. All the patients we spoke with told us they were given enough time during their appointments and the GPs and nurses listened to them. We reviewed 24 CQC patient comments cards. These gave positive comments about the practice. They commented they were treated with respect by staff who were welcoming, pleasant and listened to them.

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 although sometimes an on the day appointment with a specific GP could not be arranged. They told us they were offered a chaperone during examinations when this was appropriate.

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 81% of patients felt the GP was involving them in decisions about their care (CCG average 76%), with 87% saying the same of the nurse (CCG average 86%). The survey showed that 85% of patients thought the GP was good at explaining tests and treatment (CCG average 82%) and 88% 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 also provided evidence of patients being listened to with 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.

We saw that a range of information about various medical conditions was available in the reception area. Information about 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 services were available in the area. Patients could self-refer to these services or be referred by their GP.

An NHS Foundation Trust ran a service called Bury Healthy Minds. This provided emotional support from professionals including therapists and counsellors. It offered support and treatment for a range of issues such as stress, anxiety, the effects of long-term health problems and post-natal depression. All referrals were triaged within a week.

There was an information board at the practice giving information on emotional wellbeing and where help and support could be sought. Information about domestic violence helplines was also available.

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.

The GPs all 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. During reviews for patients with mental health needs clinicians took the opportunity to carry out any other appropriate checks and reviews and administer vaccinations such as the flu vaccination if appropriate. Also medicine reviews were arranged at appropriate intervals for patients who required regular medicines.

The practice kept a register of patients with a learning disability. They were invited for an annual health check and were contacted by telephone if they did not attend.

All patients over the age of 75 were given a named GP. Where a patient had a higher risk of unplanned hospital admittance they had a care plan in place. These care plans were monitored and updated regularly so that any increased risk could be identified and appropriate action taken. The practice worked with the Clinical Commissioning Group (CCG) to reduce the number of hospital admissions. When a patient with a care plan in place attended the A&E department they were contacted by a GP within three days to review their care plan and ensure any additional support was offered.

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 needed to use an interpreter on a weekly basis. They arranged face to face or telephone interpreters depending on the circumstances. Information on the practice website could be translated into several languages. The practice had an electronic check-in facility that could be used in four other languages including Polish.

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 area but the practice was aware of travellers in the CCG area.

All housebound patients were coded on the computer system so they could be easily identified. The practice manager told us most housebound patients were known by the district nurse team who usually carried out home visits in the area. The practice was in the process of recruiting a new nurse and they hoped they would be able to offer nurse visits in the future. GPs carried out home visits for patients who could not attend the practice.

All staff had completed equality and diversity training and the practice manager told us this training was repeated every three years. The staff we spoke with confirmed this and said any issues or advice was disseminated to them at the regular meetings that took place.

The practice was all at ground floor level and 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 normal practice opening hours were 8am until 6.30pm Monday to Friday. Extended hours were also available from 7am. The earliest appointment each day was 7.10am and the latest 6pm. In addition the practice was part of a pilot funded by the Prime Minister's Challenge Fund. This meant all patients could pre-book appointments until 8pm on weekdays and between 8am and 6pm at weekends. These appointments were within five practices in the CCG area and GPs from the practices in the CCG worked at the sessions. Although The Uplands Medical Practice was not one of the practices where patients could attend, their patients could attend any of the available practices in the area. Patients' records were available for these consultations so the GPs had all available information.

The practice explained the appointments system to us. Appointments for GPs could be booked up to three weeks in advance. These could be booked in person, by telephone or on the Internet via the practice website. Telephone appointments with a GP could also be pre-booked. Urgent on the day appointments could also be booked and a GP triage service was available each day. For this, a GP telephoned patients regarding their condition. If they felt a face to face consultation was needed this was arranged,

Good

Are services responsive to people's needs?

(for example, to feedback?)

usually for the same day. The practice manager told us that where patients requested an on the day appointment they received a telephone call from a GP as a minimum and were always seen when this was required. They said complaints had reduced since this system was introduced.

We spoke with six patients including a member of the patient participation group (PPG). Most patients told us they thought it was difficult to access appointments, but they said they were seen on the day in an emergency. Of the 24 CQC comments cards we reviewed, two mentioned that it was difficult to access appointments and one said it was difficult to get through on the telephone. We checked the appointments available at 10.50am on the day of our inspection We saw that there were five emergency GP appointments available for that day and two nurse appointments. The next routine GP appointment was available for the next working day, and the next routine nurse appointment was in four working days' time.

The most recent GP patient satisfaction survey showed that 73% of patients were satisfied with the opening hours.

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.

The complaint policy stated that written and verbal complaints were recorded. The practice manager explained that if a verbal complaint could be dealt with immediately it was not formally recorded, but where any investigation was required a record was made.

We saw evidence that all complaints made were appropriately investigated and responded to. Meeting minutes confirmed they were discussed with staff and a record of where learning needs had been identified was kept. Each year there was a review of complaints made and these were discussed in a meeting so any trends could be formally identified.

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; the lead GP told us an external company had worked with them to devise a set of values in 2011 and they were aware this needed to be revisited. Most of the staff we spoke with were not aware of these official values. 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. Partners met formally on a weekly basis and practice staff also had weekly meetings. Nurses met monthly and the practice held regular strategy meetings. The practice manager, assistant practice manager and reception manager also met weekly.

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 excellent at all levels 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.

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. They all 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. Staff told us they felt well-supported at work and the practice manager had an open door policy and was very approachable, as were the GPs.

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group (PPG) that had been active for since 2006. There were currently 12 members. The practice manager told us they tried to recruit more members via occasional newspaper advertisements, notices in the waiting room and information on the website. They were aware that the group was not fully reflective of the patient population (the youngest members were in the 35-44 age group). However, the PPG had a good mix of skills and included a carer. The practice had tried to set up a virtual PPG to encourage younger members but they had had a poor response to the idea.

The PPG met approximately four times a year, and there was an agenda and minutes for each meeting. We saw the format of the meetings had recently changed with a view to the group being more productive, and the assistant

Are services well-led?

Good

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

practice manager had an agenda of what could be discussed. This included the winter flu vaccination campaign so the practice could make plans for it in advance.

An external company carried out a patient satisfaction survey on behalf of the practice during October 2014. The results had been communicated to patients by posters displayed in the practice. We saw the PPG discussed the finding of the patient satisfaction survey. They identified that the main concern was around the availability of appointments and they made various suggestions for improvements. The practice felt that improvements had been made following the discussions.

The practice monitored the NHS Choices website and adapted the way they worked if they felt this could be accommodated. The majority of negative comments related to appointments and the practice manager told us of changes made to their system following comments that had been made. The practice also 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 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. Staff told us they were supported in their personal development.

We saw evidence that the continuing professional development (CPD) of the practice nurse was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

Staff appraisals had not taken place in the past year due to staffing difficulties. Plans were in place to ensure all staff had a formal appraisal before the end of 2015. However, GPs and the practice manager told us that they had regular one to one chats with staff to offer support, and the staff we spoke with confirmed this. The lead GP told us they had changed the management structure to ensure all staff knew who they reported to. The practice manager reported to the lead GP, and arrangements were in place for nurses to be appraised by the assistant practice manager and a GP.

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 and qualified doctors training to be GPs. We saw that feedback from students and colleges was frequently sought and we saw evidence that the practice was rated highly as a training practice.