Dr Munro and Partners

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?	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 a comprehensive inspection of Dr Munro and Partners on 4 November 2014. We found that the practice was performing at a level which led to a ratings judgement of Good.

Our key findings were as follows:

- The practice was safe, staff reported incidents and learning took place. The practice had enough staff to deliver the service.
- The practice was effective. Services were delivered using evidence based practice.
- The premises were clean and fit for purpose and equipment was available for staff to undertake their duties.
- Staff were caring and compassionate, treated patients with kindness and respect and we saw good examples of care.
- The practice was responsive to the needs of patients and took into account any comments, concerns or complaints to improve the practice.
- The practice was well led, with an accessible and visible management team, governance systems and processes are in place and there was performance and quality management information available. Quality was high on the practice agenda.

We saw several areas of outstanding practice including:

- Working in co-operation with another organisation to identify patients that were 65 or over and vulnerable to reduce the risk of fire in their homes. Patients from this practice had the highest take up of this scheme in Wigan Borough.
- The adopted apprentice scheme for administration staff that had been in place since 2008 and has resulted in 100% employment for those on the scheme. One apprentice had progressed to a supervisory role.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

The management of the practice had ensured that there were safeguarding procedures in place and had taken steps to ensure that staff followed these. Staff had received training in safeguarding children and vulnerable adults.

Patients that we talked with told us that they felt safe. There were effective medicines management processes in place, arrangements in place to deal with foreseeable emergences and equipment was checked and maintained. The practice was clean and well-maintained.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. Patient's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of mental capacity and the promotion of good health.

There were enough qualified, skilled and experienced staff to meet patient's needs. There were systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients.

Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Patients we spoke with during our inspection and remarks on comment cards said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

Summary of findings

We also observed that staff treated patients with kindness and respect ensuring their confidentiality was maintained.

Staff we spoke with were aware of the importance of providing patients with privacy. Carers or a representative were involved in helping patients who required support with making decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Wigan Integrated Neighbourhood Teams (INT), NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Patients reported acceptable access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

We found that the provider had an effective system to ensure that, where needed, the GPs could provide a consultation in patient's homes.

Staff were knowledgeable about how to access interpreter services for patients If necessary.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular appraisals and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with 11 patients who were using the service on the day of our inspection, five members of the patient participation group (PPG) and reviewed 20 completed CQC comment cards. The patients we spoke with were complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect. The comments on the cards provided by CQC were also very complimentary about the service provided.

National GP survey results published in July 2014 indicated that the practice was best in the following areas:

- 93% of respondents would recommend this surgery to someone new to the area, CCG (regional) average: 80%
- 88% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care, CCG (regional) average: 77%
- 94% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments, CCG (regional) average: 84%

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas:

- 70% of respondents find it easy to get through to this surgery by phone, CCG (regional) average: 79%
- 59% of respondents with a preferred GP usually get to see or speak to that GP, CCG (regional) average: 68%
- 65% of respondents usually wait 15 minutes or less after their appointment time to be seen, CCG (regional) average: 68%

There were 255 surveys sent out, 123 returned giving a completion rate of 48%.

Outstanding practice

The practice worked in co-operation with another organisation to identify patients that were 75 or over and vulnerable to reduce the risk of fire in their homes. The practice was involved in the partnership agreement between Greater Manchester Fire and Rescue Service (GMFRS) and Wigan Integrated Neighbourhood Teams (INT). The aim of this scheme was to identify patients at risk of a home fire and to mitigate those risks as far as was practicable. This was by means of a home fire risk assessment that was provided free of charge. The practice had a proactive approach to this scheme resulting in patients from this practice having the highest take up of this scheme in Wigan Borough.

The practice had operated an apprentice scheme that started in 2008. The scheme has led to 100% employment post scheme in this or other local practices. We saw that one of the apprentices had been given development over a number of years and had successfully achieved a supervisory role in the practice

Dr Munro and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector accompanied by two specialist advisers, a GP and a practice manager, and an expert by experience who is a member of the public trained by the CQC.

Background to Dr Munro and Partners

Dr Munro and Partners has over 12,700 patients registered and is part of Wigan Borough Clinical Commissioning Group (CCG). There are eight GP partners, a salaried GP, an advanced medical practitioner, a GP registrar and 2 foundation doctors. There are also six registered general nurses (RGN), including a practice nurse manager, and two nursing assistants. There is also a practice manager, deputy practice manager, practice secretaries, a reception supervisor and reception staff, cleaning team and two apprentices. It is a GP teaching practice.

The practice delivers commissioned services under the General Medical Services (GMS) contract.

The practice offers a range of services for its patient population. Dr Munro and Partners is registered with the CQC as a provider of primary medical services. The Practice Manager is also legally responsible for making sure the practice meets CQC requirements as the registered manager.

The practice is registered with the CQC as a provider of primary medical services that includes the following regulated activities:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Treatment of disease, disorder or injury
- Surgical procedures
- Family planning

The Surgery is open as follows:

- Monday 08:00 – 20:00
- Tuesday 08:00 – 20:00
- Wednesday 08:00 – 16:30
- Thursday 08:00 – 20:00
- Friday 08:00 – 18:30
- Saturday 08:00 – 12:00

Patients can book appointments in person, via the phone and online. Emergency appointments are available each day by ringing at 08:00. There is an out of hours service available provided by Bridgewater Community Health Care Trust and commissioned by Wigan Borough CCG.

The practice also provides cover for two local nursing and four local residential homes.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Wigan Borough Clinical Commissioning Group (CCG) information showed the practice rated as an achieving practice.

Why we carried out this inspection

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

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.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of the data from our Intelligence Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also reviewed further information on the day of the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas. We carried out an announced inspection on 4 November 2014.

During our visit we spoke with a range of staff, including the GPs, nursing and administrative staff and spoke with 11 patients who used the service. We also reviewed information from the completed CQC comment cards. We observed how people were being cared for and talked with carers and/or family members.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This information included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Information from the quality and outcomes framework, which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. Significant events were discussed at the practice education meeting. We saw that all events had been brought to a satisfactory conclusion, and that any actions were implemented as a consequence to prevent recurrence. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. All staff were aware of the procedures for raising matters to be considered at the meetings and felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked all staff members 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. A safeguarding flowchart was in the reception area and treatment rooms, and contact details were easily accessible.

One of the partner GPs was the lead for safeguarding vulnerable adults and children. They had received the necessary training to enable them to fulfil this role. This was level three safeguarding vulnerable adults and children training. 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. The GP attended multi-disciplinary safeguarding meetings when required. There was a system in place to alert a “looked after child”. A child who is being looked after by the local authority is known as a child in care or "looked after”. Some children are placed in care voluntarily by parents struggling to cope. In other cases children's services will have intervened because a child was at risk of significant harm. Children in care can be living with foster parents, at home with their parents under the supervision of social services, in residential children's homes and other residential settings like schools or secure units. In UK law children in care are referred to as "looked after children".

There was a system in place to highlight vulnerable patients on the practice’s electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. The practice had also met with the local adult social services when needed for a “best interests” meeting about patients who were a vulnerable person.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Only the

Good

Are services safe?

practice nursing team, who had Disclosure and Barring Service (DBS) checks, undertook chaperone duties. If patients required a chaperone then this was documented and held in their records.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, Egton Medical Information Systems (EMIS), and collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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 maintenance of the cold chain and action to take in the event of a potential failure. We also saw that the temperature of the fridges, used specifically for the storage of medicines and vaccines, were regularly checked and recorded. Cold chain protocols were strictly followed. We saw written records of these and this was confirmed by staff. The "cold chain" is the process of keeping medicines at a temperature range.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by the practice nursing team using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nursing team had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. The practice did accept prescription requests by telephone and followed strict guidelines that the person ordering the prescription was permitted to do so.

All prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw that the practice had a prescription security protocol.

The doctor's bag was securely stored when not in use. We checked the contents of the bag and all the drugs were in date. These were regularly checked by the nursing staff and we saw evidence of these checks. The following factors had been considered when stocking the doctor's bag:

- Medical conditions they were likely to face.
- Medicines they were confident of using.
- Storage requirements/shelf life.
- Extent of ambulance paramedic cover.
- Proximity of nearest hospital.
- Availability of 24 hour pharmacy.

Any medicines alerts that were received were reviewed by the practice manager and then disseminated to all clinical staff. These were also discussed in practice meetings.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. These schedules included daily, weekly and monthly checks. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role.

The practice has introduced the "General Practice Preventing Infection Together" (GP PIT Programme) as directed by Wigan Borough Clinical Commissioning Group. This is an Infection Prevention Programme aimed at enabling Primary Medical Care Practices to meet the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation. We saw evidence that infection prevention checks (audits) had

been undertaken and that any improvements had been identified and action plans had been put in place. We saw evidence that some of the improvements needed had already been implemented.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection prevention measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury. The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. We saw sharps containers that were labelled correctly and not overfilled. There had been no reported incidents from sharps injuries or spillage.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The consulting and treatment rooms were clean and well maintained.

The practice was registered and contracted to carry out surgical procedures. We looked at the designated treatment room used for carrying out minor surgical procedures such as the removal of small moles and skin tags and the insertion of contraceptive devices. This room was clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place and medical instruments used for minor surgical procedures were disposed of after single use. Unused medical instruments and dressings were stored in sealed packs. We looked at these and found all to be within the expiry date stipulated on the packs.

The practice had a policy for the management, testing and investigation of legionella, a germ found in the environment which can contaminate water systems in buildings. We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. Legionella testing had taken place.

Equipment

Staff we spoke with told us they had sufficient 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 displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment which included blood pressure monitors, weighing scales, pulse oximeter and the spirometer. This ensured readings taken from this equipment were accurate. We also saw that the vaccine refrigerators were regularly checked, calibrated and serviced.

We also saw that fire and intruder alarms were regularly tested, checked and serviced. There were also checks of fire extinguishers

Staffing and recruitment

There was a practice recruitment, requesting references and qualification policy in place that followed the principles of The Equality Act 2010, Employment Rights Act 1996, Human Rights Act 1998, General Medical Services Contracts Regulations 2004 and Personal Medical Services Agreements Regulations 2004. This policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS) if appropriate.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice had a lone worker policy and zero tolerance policy for violence and aggression against staff. We spoke with staff who were aware of these.

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. These included checks of the building, the

Good

Are services safe?

environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative. We saw there was a health and safety action plan completed in May 2014. This covered the premises, people, work equipment and procedures. We also saw evidence of a recent Control of substances hazardous to health (COSHH) assessment.

Identified risks were recorded. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that risk assessments had been completed for a variety of subjects including patient records, dealing with medical emergencies and patient records. We saw that any risks were discussed at practice meetings. For example, the practice had reviewed recent findings from an infection control audit, put together an action plan and worked through how to address the recommendations.

We found checks were made to minimise risk and best practice was followed. These included monitoring staff training to ensure they had the right skills to carry out their work and monitoring stocks of consumables and vaccines to ensure they were available, in date and ready to use.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator, used to attempt to restart a person's heart in an emergency. Emergency oxygen was also available if needed. . Staff that would use the defibrillator were regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if patients experience a cardiac arrest. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The clinical staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan was based on anticipation, assessment, prevention and preparation so they could respond and recover in a timely manner depending on the situation. Each risk was rated and mitigating actions recorded to reduce and manage the risk. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. We reviewed the practice business continuity plan that confirmed this. This included contingencies in what to do in the event of loss of the surgery building, loss of computer system, loss of access to paper medical records, loss of equipment and utilities. It also had information on what to do if the GP or other member of staff became incapacitated. It also detailed what to do in the event of fire or flood and response to an epidemic/pandemic and response to a major incident. There were reciprocal arrangements in place with other GP practices to ensure continuity of care where practicable.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing supporting information from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidance was disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Staff we spoke with and the evidence we reviewed demonstrated that there were appropriate clinical and nursing leads in specialist clinical areas such as diabetes, heart disease and asthma and the practice nursing staff supported this work which allowed the practice to focus on specific conditions. The practice had management plans in place to support those patients with long term conditions such as asthma, diabetes, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and those who suffer from long and enduring mental ill health.

We saw that the staff had developed an effective way of monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example the annual health checks and smears. There were systems in place to follow up by letter and then by telephone those who did not attend.

The practice was knowledgeable about health needs of older patients. They had information on patients' health conditions, carers' information and whether patients needed home visits. They used this information to provide services in the most appropriate way and in a timely manner. Staff were also able to recognise signs of abuse in older people and knew how to refer these concerns.

Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed. According to the Quality Outcomes Framework (QOF) data the practice was better than average in producing a register of patients aged 18 and over with learning disabilities, and had a better than average complete register available of all patients in need of palliative care/support irrespective of age.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP demonstrated 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

We found that people's care and treatment outcomes were monitored and that the outcomes were compared (benchmarked) against Clinical Commissioning Group (CCG) and national outcomes. According to the Health and Social Care Information Centre (HSCIC) quality outcomes framework data the ratio of expected to reported prevalence of coronary heart disease (CHD) was better than average. Also the percentage of patients with diabetes in whom the last blood pressure was 140/80 or less in the preceding 15 months was better than average.

The practice participated in clinical audit which led to improvements in clinical care. We saw evidence that the practice acted upon the results of clinical audits, and that they undertook follow up audits to ensure the management and monitoring of services to improve outcomes for patient was effective. The results of audits were shared with the team through practice education meetings.

We examined evidence that indicated that the treatment outcomes for the practice were within expected norms and also sustained over time. Information from Quality and Outcome Frameworks (QOF) quality and productivity (QP) indicators supported this. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

Effective staffing

Practice staffing included medical, nursing and administrative staff. We reviewed staff training records and

Good

Are services effective?

(for example, treatment is effective)

saw that staff were up to date with training such as basic life support, equality and diversity and fire evacuation training. We also saw that the induction programmes covered a wide range of subjects such as health and safety, confidentiality and equality and diversity. These were supported by a period of shadowing and training that was specific to a job role. For example a practice nurse induction included working with another member of the nursing staff on chronic disease management initially and then having supervised sessions to ensure that the staff member was competent to undertake these duties single handed. The GPs were up to date with their yearly continuing professional development requirements, revalidation, GP appraisal and peer review.

All staff undertook annual appraisals which identified learning needs and targets from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We looked at staff training records, that documented the training of all staff. It included core training such as infection control and safeguarding children and vulnerable adults, health and safety and manual handling. We also saw evidence of staff being trained in other disciplines such as cytology and ear care.

The practice nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. The training records we examined confirmed this.

The practice has operated an apprentice scheme that started in 2008. This involved a two year apprenticeship to gain a non-vocational qualification (NVQ) level two in business administration but they can opt to go for level three. The scheme has led to 100% employment post scheme in this or other local practices. We saw that one of the apprentices had been given development over a number of years and had successfully achieved a supervisory role in the practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically, by fax and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GPs seeing these documents and results were responsible for the action required. The practice operated a "buddy" system so that a GP would check documents and results if another was absent. All staff we spoke with understood their roles and felt the system in place worked well.

Practice clinical and nursing staff attended Clinical Commissioning Group meetings when required. The practice manager also attended a local practice manager forum monthly to share good practice and innovative ideas. The practice nurse manager attended a practice nurse forum monthly and we saw that these meetings enabled good practice to be shared amongst local colleagues.

The practice worked with the local Integrated Neighbourhood Team (INT). This included the identification of patients who may need extra care, for example from the community matron. As part of this they also reviewed who was dealing with the patient and that could be a district nurse or social services. It also identified if a patient required a falls assessment. These patients would then be put on a case management register and there would be regular meetings to review the care packages.

The practice held multi-disciplinary meetings when necessary and these included discussions about the needs of complex patients, for example those with end of life care or palliative needs. According to QOF data the practice was rated better than average in having regular (at least three monthly) multidisciplinary meetings where all patients on the palliative register were discussed. Where older people had complex needs then special patient notes or summary care records were shared with local care services including the out of hour's provision. End of life care information was shared with other local services.

The practice worked with the local learning disability team and undertook learning disability annual reviews and audits. Patients registered with a learning disability were sent information in an easy read format.

Referrals were made using the Choose and Book service. We saw evidence of the practices referral process and its effectiveness such as patients needing urgent cancer referrals.

We found the practice worked well with other agencies and health providers to provide support and access specialist

Good

Are services effective?

(for example, treatment is effective)

help to older people when needed. We found that treatment and care was delivered in line with the patient's needs and circumstances, including their personal expectations, values and choices.

The practice was knowledgeable about the health needs of patients with long term conditions. They worked with other health services and agencies to provide appropriate support.

The practice was involved in the partnership agreement between Greater Manchester Fire and Rescue Service (GMFRS) and Wigan Integrated Neighbourhood Teams (INT). The aim of this scheme was to identify patients at risk of a home fire and to mitigate those risks as far as was practicable. The common objective was to improve the quality of life for those patients who are at increased risk of fire who were over 65 and vulnerable. We spoke with the Community Safety Manager of GMFRS during our inspection and they informed us that this practice had achieved the highest take up in the borough with to date 127 patients who had signed up to the scheme.

Information sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved both internal and external to the organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data such as safeguarding information being shared with the local safeguarding authority.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system, Docman, with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. All clinical staff 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).

There was a practice policy for documenting consent for specific interventions. We saw that the GPs and practice nursing staff ensured consent was obtained and recorded for all treatment.

Health Promotion & Prevention

The practice demonstrated a commitment that ensured their patients had information about a healthy lifestyle. This included providing information about services to support them in doing this. There was a range of information available for patients displayed in the waiting area and on notice boards in the reception areas. This included information on children's health and immunisation, long term conditions such as asthma, information for people who suffer from mental ill health and learning disabilities, and general health promotions that included smoking cessation, bowel cancer, diabetes and alcohol awareness. They also provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. Staff we spoke with were

Good

Are services effective?

(for example, treatment is effective)

knowledgeable about other services and how to access them. The practice nurse team offered appointments that included cervical smears, ear syringing and cholestoral monitoring.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. This ensured the patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice worked proactively to promote health and identify those who require extra support, for example those with long term conditions. There was evidence of appropriate literature and of good outcomes for these areas as demonstrated in the QOF data. According to the Health and Social Care Information Centre (HSCIC) indicators the percentage of patients aged 65 and older who have received a seasonal flu vaccination was better than average.

Health promotion advice and information was available for people experiencing poor mental health, including people with dementia, which included information about MIND, a mental health charity.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with members of the Patient Participation Group and 11 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Over the last year six comments had been posted by patients on the NHS choices website. Four of the comments posted were very favourable about the practice and one mentioned how difficult it is to get an appointment. The other was a comment about a GPs mobile phone going off during a consultation. However the practice did respond to this comment and informed the person that they had circulated to the GPs a reminder that mobile phones should be switched off during surgery sessions and apologised for the distraction.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 94% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services through 'Language line' were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted the GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. There was also a notice board in the waiting area with information for carers.

Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments. Longer appointments were available for people who needed them and those with long term conditions. All patients needing to be seen urgently were offered same-day appointments.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and told us they had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. They had forged close links with the hospice team and introduced the local end of life care plan.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. For example patients who were housebound were identified and referred to the practice nursing team to receive their vaccinations.

There was a call and recall system in place for chronic disease management. The administrative team run searches on the computer system monthly and send letters out to patients who require a review. The practice follow up with further letters and phone calls if necessary.

Each patient contact with a clinician was recorded in the patient's record, including consultations, visits and telephone advice. The practice had a system for transferring and acting on information about patients seen by other doctors and the out of hour's service. There was a reliable system to ensure that messages and requests for visits were recorded and that the GP or team member received and acted upon them. The practice had a system in place for dealing with any hospital report or investigation results which identified a responsible health professional and ensured that any necessary action was taken. The was a system to ensure the relevant team members were informed about patients nearing the end of their life. There was also a system to alert the out of hour's service if somebody was nearing the end of their life at home.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice provided good disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms. There were comfortable waiting areas for patients attending an appointment and limited car parking was available nearby. There were disabled toilet facilities.

Access to the service

Comprehensive information was available to patients about appointments in the practice guide and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was available for patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice.

The national GP survey results published in July 2014 showed that 70% of patients said it was easy to get through to the practice to make an appointment. 91% of patients said they found the receptionist helpful once they were able to speak with them. Patients we spoke with showed that patients did not have difficulties in contacting the practice to book a routine appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

When necessary longer appointments were given to older people and those with diagnosed with mental ill health and home visits had been arranged if necessary.

The practice provided a range of services for patients of working age, including those recently retired, to consult with GPs and nurses, including on-line booking and telephone conversation. Patients were also able to book a consultation with a GP through the extended hour's service. The appointments system was regularly reviewed to try to maximise timely access to services for this population group.

Listening and learning from concerns and complaints

We arranged for a Care Quality Commission (CQC) comments box to be placed in the waiting area of the practice several days before our visit and 20 patients chose to comment. All of the comment cards completed were very complimentary about the service provided.

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. There was a complaints/suggestions box in the waiting area and staff told us it was checked regularly. There was also complaints information available in an easy read format for those patients with a learning disability.

Patients knew how to raise concerns or make a complaint. Information on how to complain was displayed in the reception area and in the practice guide. We looked at seven complaints received in the last twelve months and found they had been satisfactorily handled and dealt with in a timely manner. Each person received a letter of apology from the practice and the complaint was resolved to the satisfaction of the patient. We also saw evidence that complaints had led to discussions at practice meetings to prevent recurrence and staff training

Patients were informed about the right to complain further and how to do so, including providing information about relevant external complaints procedures. Whilst none of those spoken with had needed to complain, they all said they would be able to talk to the staff if they were unhappy about any aspect of their treatment.

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 clear vision to deliver high quality care and promote good outcomes for patients. They had a statement of purpose to provide and deliver general practitioner services to the patients registered at Dr Munro and Partners. Their aim is excellence in all they do, achieved through a highly motivated, well-trained team that is committed to providing a reliable, accessible service by working in partnership with their patients.

They endeavoured to achieve this by creating and maintaining a friendly, stress free environment for staff and our patients, communicating effectively with staff and patients and encouraging and sharing feedback at all levels resulting in the creation of a learning organisation. They actively sought suggestions for improvement from staff and patients and listened and acted on the feedback they receive. They aimed to be positive and forward thinking that encourages innovation, creativity and the pursuit of best practice. They also aimed to work effectively as a team by actively seeking to understand the needs of others and helping everyone to achieve common goals and therefore earn the respect of the community and being regarded above all as a caring practice.

Staff we spoke with were knowledgeable about this and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The GP partners took active leadership roles for overseeing that the systems in place were consistently being used and were effective. There were managerial leads from the GP partners for finance, property, prescribing, GP training, complaints, chronic disease management (CDM) and staff. The nursing staff also provided the lead for nursing management, CDM, infection control, family planning and sexual health. There was also a system of succession planning in place that ensured that the level of service to the patient population was consistent.

Practice staff were clear about what decisions they were required to make, know what they were responsible for as well as being clear about the limits of their authority. It was clear who was responsible for making specific decisions, especially decisions about the provision, safety and adequacy of the care provided at practice level and this was aligned to risk. The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impact on the quality of care.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via paper and computer copies. We looked at a number of these policies and procedures and confirmed most were reviewed annually and were up to date. The ones we looked at included health and safety at work, confidentiality, information systems security, recruitment and the whistleblowing policy.

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

The practice had arrangements for identifying, recording and managing risks. We saw a number of risk assessments which addressed a wide range of potential issues, such as health and safety risks. We saw that the risks were regularly discussed at practice meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example training, support arrangements and recruitment, which were in place to support staff. We were shown the staff handbook that was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

There was a schedule of meetings within the practice. These included joint clinical and non-clinical meetings,

Are services well-led?

Good

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

regular business meetings and a biannual multi-disciplinary business planning meeting. Staff told us these meetings helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to the GP partners, practice nurse manager and practice manager. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

We saw evidence that showed the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

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

The practice and all staff recognised the importance of obtaining and acting upon the views of patients and those close to them, including carers. A proactive approach was taken to seek a range of feedback. There was an active patient participation group (PPG) that collected patient feedback on behalf of the practice.

We reviewed the minutes of the PPG annual general meeting and also their action plan for 2013-14. Some of the comments they collected were about appointment waiting times and the practice acknowledged that a ten minute appointment may be insufficient time to deal with complex problems that patients present with. As a result consultations were increased from 10 to 12 minutes with the aim of reducing the patient's waiting time.

The PPG produced a newsletter for the patient population. The latest newsletter was produced in November 2014 and informed patients what the PPG had done since the last newsletter. For example it highlighted the popularity of the walking group and how it has been encouraging new members to the PPG, including younger people. The newsletter also highlighted what they aim to do next and the main area was the promotion of the text message service for patients and also access to patient records by the patient.

We also reviewed minutes of the PPG meetings. We noted that GPs and other practice staff attended PPG meetings. The PPG displayed information on notice boards and had a dedicated area on the surgery website. They also had an electronic message board in the waiting room which the PPG managed. The PPG also championed a dementia group to support those carers in this population group and provided a meet and greet service at the flu vaccination clinics. Members of the group also attended CCG meetings. The also promoted the practice at the local fete.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to develop through training and mentoring. We saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended on occasion. There was specific training undertaken by the GPs which included mandatory training, information governance, safeguarding, and cytology. Nursing staff also had specific training in such areas as chronic disease management. All non-clinical staff complete mandatory training but also other training for their roles such as confidentiality and equality and diversity. There was also a series of management and personal development modules bespoke to management roles such as employment law and supervisory skills.

The practice was a GP training practice and was involved in the vocational training of fully qualified doctors who wish to enter general practice.

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