

New Collegiate Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at New Collegiate Medical Centre on 30 June 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Practice staff understood the importance of identifying and reporting when things had gone wrong.
- Opportunities for learning from these events to prevent them reoccurring was maximised.
- Clinical audits were regularly used to ensure the most effective and appropriate care was offered.
- Patient's needs were assessed and care was provided in line with best practice guidance.
- Staff had received training appropriate to their role

- Patients told us that they were treated with compassion, dignity and respect. They were happy with the care they had received
- The practice recognised the needs of the population it serves and delivered it's services accordingly.
- The practice provided a safe environment for the care of it's patients, facilities were clean and well maintained. Equipment was looked after appropriately.

We saw several areas of outstanding practice including:

- Audits undertaken demonstrated the practice was performing well in the early diagnosis of dementia
- The practice offered a weekly sexual health screening clinic, along with a full contraceptive service. This service was also available for patients who were not registered with the practice.

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

The provider should:

Summary of findings

- Ensure that relevant staff receive training in regards to the Mental Capacity Act 2005

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing services that are safe. Staff recognised the need to raise concerns around safety and demonstrated good awareness of safeguarding issues. We saw evidence that significant events and complaints were investigated, with changes to practice implemented as a result to prevent reoccurrence. These learning points were disseminated to staff appropriately. There were enough staff to keep people safe. All equipment was regularly maintained to ensure it was safe to use.

Good



Are services effective?

The practice is rated as good for providing services that are effective. Evidence was provided that demonstrated staff received training and support. National Institute for Health and Care Excellence (NICE) guidance was referenced and used to ensure treatment followed best practice guidelines. Doctors and nursing staff completed audits regularly in order to ascertain the effectiveness of their clinical practice, and the results of these audits were used to modify and improve the effectiveness of the treatment offered.

Good



Are services caring?

The practice is rated as good for providing caring services. The patients we spoke to and those offering feedback via our comment cards told us that practice staff treated them with dignity and respect. Patients were very complimentary about the practice. The practice actively seeks to ensure that the needs of those patients with caring responsibilities are catered for so that they are offered appropriate support. We were told by patients of practice staff being proactive in chasing up appointments on their behalf to ensure they received appropriate care following referral on to secondary care services.

Good



Are services responsive to people's needs?

The practice is rated as good for being responsive to the needs of its patient population. Members of the Patient Participation Group (PPG) told us how the practice quickly implemented change following suggestions made by the group in order to improve the patient experience. A dementia screening programme was established for older patients and those who presented with mental health issues, as part of the enhanced services offered by the practice. Longer appointments were available for those patients with learning difficulties.

Good



Summary of findings

Are services well-led?

The practice is rated as good for providing services that are well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to manage all activity. There was a large, active Patient Participation Group, with which the GPs fully engaged and implemented change following suggestions made. The practice was a well established training venue for trainee GPs, often being asked by the North Western Deanery to mentor trainees who need extra support during their training. Staff received thorough inductions on commencement of their employment with the practice, and were afforded regular training and appraisals to support their continued professional development.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people. The practice had a low number of patients, 32 in total, who lived in one of three local residential or nursing homes (the number of people aged over 65 living in the practice area is approximately 1320). Care plans were in place for these patients, who were visited on a regular basis by the GPs or practice nurses. All patients over 75 had a named GP. The practice worked closely with the Crisis Response Team and had effective communication with the Active Case Manager to ensure patients who were vulnerable received the appropriate care and response when unwell.

The Practice nurses offer a phlebotomy service via home visits for the housebound.

The practice had a proactive programme of flu and shingles prevention with 82% of patients over 65 having been immunised, compared with 76% across the Clinical Commissioning Group (CCG).

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice nurses were proactive and had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were regularly made when needed.

One GP was the cancer champion and chaired bi-monthly palliative care meetings with a multi-disciplinary team, which included the practice nurses, district nurses and community specialists.

Advanced care plans were in place, not only for patients with a cancer diagnosis but for those with other life limiting illnesses. These included the patients' preferred place of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. The practice had a consistent uptake of their child immunisation programme, with weekly child development and vaccination clinics held. Immunisation of children up to 12 months old was 96.4%, comparable to the CCG at 96.1%. There was also comparable uptake in the 24 months to five years age group with the practice achieving over 88.9% (88% CCG).

The practice had comprehensive systems in place for the safeguarding of children and young people, with bi-monthly meetings with the health visitors and the GP practice lead for

Good



Summary of findings

safeguarding. Staff were able to demonstrate a good understanding and were proactive in safeguarding children from the risk of harm or abuse. The practice had system alerts to identify those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role.

Families were actively contacted within three days of discharge when a child had been admitted into hospital due to their asthma condition. A review was then arranged with the practice nurse or GP as required.

The practice offered a weekly sexual health screening clinic, along with a full contraceptive service. This service was also available for patients who were not registered with the practice.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). The practice had previously offered extended hours surgery but this was not regularly attended by patients in this group.

The practice had acknowledged the needs of the working age population, those recently retired and students and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Telephone consultations were available, along with telephone triage by GPs or practice nurses.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice took part in the local enhanced service for patients with learning disability (LD). There were currently 19 LD patients registered with the practice and the practice worked closely with the Community Learning Disability team. Annual general health reviews were undertaken and these were on going. Longer appointments were given to enable an appropriate length of time to discuss health and general well-being issues with the patients and/or the patient's carer.

A register of carers was maintained by the practice. The practice nurses explained how time was spent ensuring that carers health and well-being was discussed with them at the same time as the patient's appointment. This avoided having to leave them on a separate occasion to visit the surgery.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for its care of people experiencing poor mental health (including people with dementia). It was acknowledged by the practice that they had a high number of patients who experienced episodes of poor mental health. We spoke with one patient who was very positive about the care, treatment and support he had received from one GP in particular.

There was a range of information available for patients and family signposting to community groups and mental health advice services. The practice discussed some issue with access to secondary (hospital) mental health services and it was clear there was a responsive service offered to those patients to maintain their health and well-being.

The practice nurses had been trained and were undertaking effective monitoring and audit of patients who were on Lithium treatments. Lithium is used in the treatment for patients with bipolar disorder and depression and requires regular monitoring of blood levels and general health checks.

National health data indicated that 78.3% of patients with a diagnosis of dementia had received a review of their care (75.9% CCG and 77.9% national comparators). An audit undertaken demonstrated that the practice was performing well in the early diagnosis and treatment of dementia.

Summary of findings

What people who use the service say

We received 32 CQC comment cards. All 32 cards praised the practice, with many positive comments made regarding the cleanliness of the premises and the fact that staff treated patients with dignity and respect. Many of the cards also indicated a high level of satisfaction with the advice and treatment they had received from the doctors. However, three of the cards did make reference to the fact that it could be difficult to get an appointment with a GP at short notice, particularly if patients wanted to see a particular GP.

A patient we spoke with in the waiting room on the day of inspection confirmed that they felt they were treated with dignity, empathy and respect by practice staff. They

reported that in their experience, patients and carers were involved in the decision making process during treatment and that they were well supported emotionally by the doctors.

During the inspection we met with five patients who were also members of the Patient Participation Group. They told us that the practice actively sought out feedback from their patients, and responded to this feedback, implementing changes to provide a better experience for their patients. While some concern was raised that it could be difficult to make an appointment with a named GP in a timely manner, the PPG members acknowledged that the practice had responded swiftly to their concerns in this regard and implemented changes to address this.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure that relevant staff receive training in regards to the Mental Capacity Act 2005

Outstanding practice

- Audits undertaken demonstrated the practice was performing well in the early diagnosis of dementia
- The practice offered a weekly sexual health screening clinic, along with a full contraceptive service. This service was also available for patients who were not registered with the practice.

New Collegiate Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, with a second inspector also present. The team also included a GP and a specialist advisor who was a Practice Manager.

Background to New Collegiate Medical Centre

New Collegiate Medical Centre is located in the residential area of Cheetham in North Manchester. It is part of the NHS North Manchester Clinical Commissioning Group (CCG). Services are provided under a General Medical Services (GMS) contract with NHS England. The practice population currently consists of 13,152 patients, with patients residing in the North Manchester area, as well as some city centre post codes. The patient list are 48% female and 52% are male. The patients accessing services at the practice are from a range of ethnic backgrounds, including; Pakistani and other Asian backgrounds, African, Indian, Chinese and British.

The practice population includes a higher proportion of children and young people when compared to the national average (aged 0-4: 9.1%, 5-14: 15.9% and under 18: 19.9%, compared to the national averages of 6%, 11.4% and 14.8% respectively). The practice also has a lower proportion of older patients; 10.1% of their population are over 65, 5.1% over 75 and 1.5 % over 85, compared to the national averages of 16.7%, 7.6% and 2.2% respectively.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice caters for a population where a higher proportion of patients are unemployed; 10%, compared to the national average of 6.2%.

The practice offers morning, afternoon and evening surgeries every weekday by appointment. It is possible for patients to request to see a named doctor of their choice. Surgery times are 8:45 – 10:45, 13:25 – 15:45 and 15:55 – 18:00.

Between 8:30 and 10:30 a telephone triage service is offered for patients requiring urgent medical attention. Patients using this service will be called back by a GP or Practice Nurse, and either offered advice over the telephone or invited to attend the emergency surgery that day. In this instance it is not possible for patients to specify which doctor they see.

When the practice is closed, patients are advised to access Out of Hours services offered locally by the provider GoToDoc. Patients of the practice also have access to seven out of hours appointments each week (five through the week, one on each weekday evening, and one each on Saturday and Sunday) offered at a local Primary Care Centre. The appointments are allocated to patients by the practice.

At the time of inspection, the practice had five partner GPs (three female and two male) and two salaried GPs (one female, one male). Two practice nurses are also employed

Detailed findings

by the practice, along with a Health Care Assistant, three secretaries, seven receptionists and two administrators. Being a training practice, there are often trainee GPs on site also.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes (QOF) 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 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 30 June 2015. During our visit we spoke with a range of staff including four GP partners and a salaried GP, the practice manager, practice nurses, health care assistant, a range of administration and reception staff and spoke with patients who used the service. We observed how people were being cared for and we reviewed a range of information provided by the practice leading up to and during the inspection. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

Systems were well established which demonstrated the practice identified risks and made improvements to maintain patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

Learning and improvement from safety incidents

Minutes of staff meetings recorded in 2015 provided evidence that incidents, events and complaints were discussed and shared. We saw that where required, actions were taken to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints. For example we saw that significant events where a child with whom there were safeguarding concerns failing to attend a hospital appointment were recorded, analysed and appropriate learning outcomes set to minimise reoccurrence. The practice also documented events such as early cancer diagnosis to promote examples of good practice.

Reliable safety systems and processes including safeguarding

The practice had comprehensive systems in place to safeguard children and vulnerable adults.

All staff had received training appropriate to their job role, with all clinical staff trained to Safeguarding level 3. Both clinical and non-clinical staff we spoke with demonstrated a good understanding of safeguarding. Clinical staff gave examples when they had raised safeguarding issues and were positive about the support they had received. A specific example given centred around concerns regarding a female patient who had possibly been subjected to Female genital Mutilation. The GP reported making an appropriate referral to the safeguarding team.

Comprehensive guidance was in place, with one GP identified as lead for safeguarding, along with a deputy GP

and an administration lead. However the policy made reference to the Independent Safeguarding Authority, which no longer exists and replaced with the Disclosure and Barring Service. We discussed this with the practice manager who assured us this would be amended.

There was a list of clinical and non-clinical staff who undertook chaperone duties. Staff had been appropriately trained and guidance was in place. Posters informing patients that a chaperone was available were displayed in each consulting and treatment rooms, as well as in the waiting areas.

Medicines management

We saw medicines were appropriately stored in the treatment rooms and fridges and were only accessible to authorised staff. There was a current policy and procedures in place for medicines management including cold storage of vaccinations. A checklist was completed daily for the three fridges to ensure the fridges remained at a safe temperature. Staff were able to explain the procedure to maintain the required temperature of vaccines or potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines were found to be in date.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance, as these were tracked through the practice and kept securely at all times. Patients were able to request repeat prescriptions on line.

Medicines for use in medical emergencies were kept securely in the treatment rooms. Stock levels and expiry dates were checked on a regular basis. There was oxygen kept by the practice for use in case of an emergency.

Cleanliness and infection control

All areas of the practice were clean and well organised. We saw there were cleaning schedules in place and cleaning records were kept.

Infection prevention and control guidance was in place and indicated the nominated leads. Staff were aware of their

Are services safe?

responsibilities and who to report any issues to. Staff had received training and the nominated leads were able to access appropriate guidance and additional training if required.

Treatment rooms were clean, well-organised and free from clutter. Disposable privacy curtains were used and dated when required changing. Personal protective equipment, such as gloves and aprons were available in all areas. Hand gels and soap were well stocked and available in all areas.

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

Patients did not raise any concerns about the cleanliness of the practice.

Equipment

All equipment was maintained in good condition. All electrical equipment was portable appliance (PAT) tested. Equipment was serviced and maintained as required and records verified this. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Equipment for patient's self-testing of blood pressure was available in the waiting area, with instructions for use.

Staffing and recruitment

The practice had a comprehensive recruitment policy and used the services of an external company for HR guidance. We reviewed the personal files of six members of staff, including clinical and non-clinical staff. We found these to be well maintained and contained all the required information to demonstrate staff were safely and effectively recruited and employed. These included personal identification checks, application forms, interview notes, references, disclosure and barring (DBS) checks, health checks and training certificates.

There was an appropriate system to make checks on the registration of clinical staff with the relevant professional bodies, such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC). GPs and nurses had appropriate indemnity insurance in place.

There was an established induction process for all grades of staff and a comprehensive induction hand book.

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 site. All new members of staff employed were supported through a comprehensive induction programme which allowed for orientation around fire safety and health and safety protocols. This induction process was documented in the practice's induction hand book. The induction hand book also detailed comprehensive protocols for new staff on how to action patient test results as well as including useful contact telephone numbers.

A map of the building was displayed clearly on all floors to allow visitors to identify a means of emergency exit should the need arise.

Arrangements to deal with emergencies and major incidents

There were appropriate arrangements in place for staff to deal with emergencies. The practice had emergency medicine kits for anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly). Staff knew where these were held and how to access them. Oxygen and an automated external defibrillator (AED) were available for use in an emergency.

Emergency medicines and equipment were checked on a regular basis, with records maintained. Staff had undertaken annual training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR).

There was a current up to date fire policy in place. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

We saw that the practice had a comprehensive business continuity plan to ensure continued delivery of services in the event of a major incident. This plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice.

Are services safe?

All policy documents were stored on the practice's shared computer drive allowing staff access to them. Staff had access to alternative methods of access to electronic records should their practice network system fail during surgery hours.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found clinicians and staff were familiar with the needs of each patient population group and the impact of the socio-economic environment where patients lived. The partner GPs proactively monitored the service they provided against a range of local and national benchmarking tools to measure their effectiveness. National and professional guidance from organisations such as the National Institute for Health and Care Excellence (NICE) was utilised in clinical decision making; for example, the practice had a policy in place regarding Type 2 diabetes titration which drew reference from relevant NICE guidelines.

Management, monitoring and improving outcomes for people

The practice had a clear understanding of the different population groups they provided service for. Care plans were in place for the older population and those with long term conditions.

One GP in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained to assist. They carried out clinical audits on their results and used the results to inform their learning and changes required to practice. The GPs discussed audits recently carried out by the practice. For example, in June 2015, the practice Nurse re-audited how the practice monitored the long term use of lithium in their patient population experiencing thyroid disorders and mild cognitive and memory impairment. This was a re-audit, the first being carried out in 2011. We also saw evidence that the practice regularly audited the coding of patients experiencing dementia in their records (in March 2015 and June 2015). This audit process was used to monitor whether referrals on to services such as the memory clinic were being made appropriately. It was seen that these audits were followed up and repeated appropriately in order to maximise learning from them and inform changes to practice, therefore ensuring patients received the necessary care.

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook clinical audits. QOF is a voluntary national

performance standard. QOF data showed the practice achieved 877.4 out of a possible 900 points and performed above the average for the local clinical commissioning group.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with mandatory training such as annual basic life support and safeguarding.

GPs were up to date with their yearly continuing professional development requirements and had either 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff appraisals had been undertaken, with input from a GP, for the nursing staff. Staff were able to identify any areas for development and when we spoke with staff they were very positive about support and opportunities for training and development.

Working with colleagues and other services

The practice had coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register and palliative care register. The practice referred patients appropriately to secondary (hospital) care and other services. Test results and hospital consultation letters were received into the practice either electronically or by paper.

The practice holds bi-monthly multi-disciplinary meetings to discuss patient's receiving end of life care as per the Gold Standards Framework. This ensures the care received by patients is coordinated and most appropriate to their needs.

Information sharing

We found referrals were made to secondary care (hospital) in a timely way.

We found that staff had all the information the practice needed to deliver care and treatment to patients. We saw that all letters relating to blood results and patient hospital discharge letters were reviewed by the GPs or nurses via the

Are services effective?

(for example, treatment is effective)

electronic records system. Task allocation to GPs and nurses was utilised effectively to improve workflow and ensure patient information was reviewed in a timely manner.

The practice had robust information sharing protocols in place with both their Out of Hours provider and Accident and Emergency.

A monthly newsletter was made available for patients electronically, on the practice website or from the practice. This gave patients a general update on staffing news, surgery closures, services offered, feedback from patients from the Friends and Family test and appointment access information. A practice information leaflet was also available and the practice had a Twitter account that was used to 'tweet' weekly updates around practice information to its followers.

Consent to care and treatment

There was a current consent policy in place. Clinical staff demonstrated an 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).

Consent was obtained from patients before undergoing minor surgical procedures or insertions of intra uterine devices (coils). Consent forms were signed and scanned onto the patient's electronic record.

We found clinical staff had some awareness of the Mental Capacity Act 2005; however, there was no evidence to demonstrate they had received any formal training.

Health promotion and prevention

There was a wide range of health promotion and health advice leaflets in both waiting areas. Contacts for various health and social care services in the local community, such as Age UK and MacMillan cancer care, mental health organisations were available. Health advice leaflets were available in a number of different languages. Information on how to access services out of hours was also displayed.

The practice offered a health check to all new patients registering with them. They offered a full range of immunisations for children, travel clinics and yellow fever vaccines and flu vaccinations in line with current national guidance.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The staff showed an awareness of the patients' need for privacy and of the importance of confidentiality. In the reception area, computer screens were positioned out of sight to avoid onlookers being able to observe confidential information.

Consultations took place in consultation rooms positioned away from the waiting areas and these rooms had an appropriate couch for examinations and had curtains in order to maintain privacy and dignity.

The patients we spoke to on the day of inspection, as well as many of those who had completed comment cards, told us that they were treated with dignity and respect by the staff in the practice.

Patients were offered the opportunity to have a chaperone present in the room during their consultation. Posters advertising this option were seen clearly displayed in the waiting rooms as well as in treatment rooms.

The patients we spoke with felt that they were involved in their care, with treatment options and choices clearly explained to them.

One patient who suffered with mental health difficulties told us that practice staff had been proactive in chasing up an appointment with the local mental health service on his behalf.

Care planning and involvement in decisions about care and treatment

In the 2015 National GP patient survey 76.2% of respondents at the practice said the last GP they saw or spoke to was good at explaining tests and treatments and involving them in decisions about their care. This was above the CCG and national average of 72.5% and 74.6% respectively.

Staff told us that interpreter services were utilised for patients whose first language differed from the languages spoken by the doctors or nurses, in order for their treatment options to be adequately explained to them.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including a Macmillan cancer care information point.

Staff told us that they actively signposted patients to other support services, for example for support around drug and alcohol dependency.

The practice maintained a register of those patients who also have carer responsibilities. During annual review appointments for those in their care, time was taken to ensure all was well with the carer; additional time was specifically added to the appointment slot to ensure this was done.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a number of enhanced services which included unplanned admissions, dementia assessments and services for patients with learning difficulties (LD). The practice had identified patients who had multiple complex conditions, which could increase the risk of unplanned hospital admissions or attendance at accident and emergency. Care plans were in place for these patients.

Staff confirmed patients who had learning difficulties were given longer appointments for routine visits and annual general health reviews. The practice held a register of vulnerable children and adults.

A dementia screening programme was in progress for older patients and those who presented with mental health issues as part of the enhanced services offered by the practice.

We were told care plans were in place for patients diagnosed with mental health problems. The practice liaised with the community mental health team to ensure appropriate care and treatment was provided.

Care plans were also in place for patients who required palliative care for cancer or other life limiting conditions.

The practice had an active Patient Participation Group (PPG) and we were told, a registered membership of 60 patients. We spoke with five members of the group. We were told the practice was responsive to the needs of the patients. They praised the practice for the speed with which they had implemented change following recommendations made by the group; for example, when concerns had been raised in the past regarding accessing appointments in a timely manner at the practice, the telephone triage system was introduced to alleviate some of the demand for urgent appointments on the same day. We were also told of the responsiveness of the GP in ensuring timely and appropriate care into secondary (hospital) care.

Discussion with the GP partners highlighted that they had reflected on the forecasted growth in the practice's

population by approximately 20,000 people in the coming years; they told us that the space afforded to them in their current practice building was sufficient to cater for such a population increase, clinic staff permitting.

Tackling inequity and promoting equality

The practice facilities enable appropriate access to those patients in wheelchairs and there was disabled toilet. There was a lift but if patients could not access treatment or consultation rooms on the first floor, the GP or nurse would undertake consultations in the lower floor rooms.

The practice provided services to patients from a range of different ethnic and cultural backgrounds.

An interpreter service was utilised at the practice as required in order to facilitate effective access to services when a patient's language was not spoken by the doctor or nurse. In these cases, extended appointments were offered to ensure treatment could be explained fully. We also saw information and advice leaflets in the patient waiting areas that had been translated into a number of different languages.

Access to the service

The practice had previously offered extended opening times but found that the uptake was poor. Telephone consultations were offered, along with a triage service to try to meet the demand for on the day appointments.

Appointments and repeat prescription requests could be made via the practice website.

Respondents to the 2015 National GP survey indicated that 88.3% were happy with telephone access to the practice and 77.4% responded that they felt they had a good overall experience in making an appointment. Both these results were higher than the CCG average of 76.8% and 72.8% and higher than the national average of 75.5% and 74.6%. Respondents also rated the practice higher than the CCG and national average for satisfaction with opening hours. This was 80.4% compared with 77.7% and 76.9% respectively.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

Are services responsive to people's needs? (for example, to feedback?)

When we reviewed the information recorded in investigating complaints, we saw these were managed appropriately and in line with required timescales. We saw evidence complaints were routinely discussed at practice and clinical meetings so learning could be implemented.

Patients we spoke with said they were aware of whom to address any complaint about the practice to but they had not felt the need to make any complaints.

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 demonstrated a clear vision; to provide high quality medicine that was evidence based and to promote an open and honest environment. The staff we spoke to on the day of inspection were able to articulate these values to us. Discussion with the GP partners confirmed that they had considered how the likely change in local population size over the coming years would affect the practice and that they were confident that they would be able to cope with that increased pressure.

Governance arrangements

There was an established system in place for assessing and monitoring the quality of service provision. This included delegated lead roles and duties for clinical and non-clinical staff for areas such as complaints management, significant events and risk management.

Staff we spoke with generally knew the leads for clinical and non-clinical areas but said they would speak with either the GPs or lead receptionist to raise any queries.

The practice had policies and procedures in place to give staff guidance. These were dated appropriately and reviewed regularly. The electronic system had a shared hard drive for the location of policies or protocols, and staff were easily able to access these.

Clinical audits were undertaken by the GPs throughout the year to audit their performance and change practice as required for the benefit of patients they supported.

Leadership, openness and transparency

Staff had specific roles within the practice for example safeguarding and infection control. We saw that the practice had a Whistleblowing policy in place. The staff we spoke to during the day were aware of these policies and who the relevant leads within the practice were.

We saw minutes as evidence that regular staff meetings took place. Minutes included lists of attendees and apologies for absence, so there was a clear audit trail of what information had been disseminated to which staff.

Staff told us that they felt able to raise any issues or concerns with the practice management, and that these would be acted upon accordingly.

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

The members of the Patient Participation Group we spoke to praised the practice for the way they implemented change swiftly on the basis of suggestions made by the group. For example, installing an automated 'check in' device for patients to use on arrival at reception, in order to cut down on cues at the reception desk, and the introduction of the telephone triage and consultation system to alleviate pressure on demand for appointment slots through the day.

Staff at the practice were able to raise concerns or ideas to management either formally during structured staff meeting or informally. Staff felt that feedback raised was acted upon appropriately by the practice.

Management lead through learning and improvement

The practice was an established training and teaching practice approved by North Western Deanery. There was a strong ethos on clinical education and improvement and the practice was often requested to support trainees. As part of their role as a training practice, they were visited every three years by the Deanery to ensure they maintain the standards required to train new doctors. The GPs in the practice told us that they regularly carried out case analysis with the trainee doctors working in the practice to support their learning.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities. We were shown training logs for each member of staff confirming this.

Onward referrals made by GPs at the practice into secondary care were subject to peer review prior to being sent, to allow for learning and feedback as to the appropriateness.

Two of the practice's GPs sat on the local CCG board, with one of the partners being the CCG's chief accountable officer. This ensured robust channels of communication were maintained between the practice and CCG, and that the practice remained current with any changes implemented by the CCG swiftly put in place.