Care Quality Commission

Saxena Bowden Saxena

Quality Report

Moorgate Primary Care 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

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

Detailed findings from this inspection

Our inspection team	9
Background to Saxena Bowden Saxena	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Minden Group Anchor Practice (Drs Saxena Bowden and Saxena) on 5th May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Risks relating to recruitment checks (such as Disclosure and Barring Service Checks for all staff) had been identified by the practice prior to our inspection and were being actioned.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff received support and training appropriate to their roles, with the exception of regular appraisals. This had been identified by the practice prior to our inspection and further training needs had been identified and appraisals had been planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Some patients said they found it difficult to make an appointment with a named GP in a timely manner. However they said there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a newly embedded leadership structure and staff felt very supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

The provider should fully implement it's staff appraisal plan

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 safe services. Staff understood their responsibilities to raise concerns and record safety incidents and near misses. They fulfilled their responsibilities in these areas. Lessons were learned and communicated within the practice to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and there were enough staff to keep patients safe. There were reliable systems and processes in place to keep people safeguarded from abuse. The practice had identified the need to share significant events and near misses more widely with the other practices in the Minden Group. They were discussing ways in which to do this with the other practice leads.

Good

Are services effective?
The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff at the practice worked with multidisciplinary teams to promote good outcomes for patients. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Appraisals had not been completed for two years but the practice had identified that action was required in this area. Personal development plans had been initiated and dates for implementation were being planned

Good

Are services caring?
The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good

Are services responsive to people's needs?
The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Good

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Some patients said they found it less easy to make an appointment with a named GP but most patients said that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evidenced and shared with the CCG.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were aware of the vision and their responsibilities in relation to this. There was an evident leadership structure and staff felt supported by management. The practice had a number of policies and procedures easily accessible by all staff and they held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Newly employed staff had received inductions and regular performance reviews and all staff attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice were aware of the need to offer an annual health check for all those patients over 75 years and had identified this in their future planning. They were involved in the £5 per head scheme to provide extra training for a dementia lead in the practice to enable them to identify, diagnose and treat more patients with dementia at an earlier stage of the disease.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff and advanced nurse practitioners had lead roles in chronic disease management with the input from GPs as and when required. GPs had lead roles in conditions such as mental health, cardiovascular disease and rheumatology. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice held regular chronic disease management clinics and practice nurses visited housebound patients to administer flu injections and carry out other health checks where necessary. The practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability who received regular follow up and annual health checks. The three Minden practices shared rotation of registration and no bias was made towards any patients who wished to register. They regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients had been told about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). They regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia. One of the GPs had a special interest in dementia and was the lead for the practice. Patients experiencing poor mental health were given information about how to access various support groups and voluntary organisations such as MIND and SANE. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff were advised on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with nine patients and reviewed comments from 26 Care Quality Commission (CQC) comments cards which had been completed. All of the comments reflected praise for the practice, the GPs and the nursing and administration staff. Six patients commented via the comments cards that appointments were sometimes difficult to obtain. Patients we spoke to praised all of the staff and in particular praised the nurses for their kindness and patience. Comments included good feedback for the GPs who were said to be thoughtfull, thorough and always caring, informative and attentive.

Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. They were satisfied with the cleanliness of the environment and the facilities available and said they were treated with dignity and respect. There were mixed responses on whether it was easy to see the GP they wanted to see and some said they had to wait a long time for an appointment with a specific GP.

We reviewed the results from the latest GP Survey where 117 responses out of 351 were received. This was a 33% completion rate. The practice scored higher than the local CCG average in the following three aspects :

79% of respondents found t easy to get through to the surgery by telephone - Local (CCG) average: 68%

93% of respondents said the last appointment they got was convenient - Local (CCG) average: 92%

85% of respondents described their overall experience of this surgery as good - Local (CCG) average: 84%

In addition, 96% had confidence and trust in the last GP they saw or spoke to and 97% said the same of the nurse. 89% said the last GP they saw or spoke to was good at listening to them.

The practice received two positive feedback reviews on NHS choices saying the GPs were were the best the patient had ever had and that GPs always listened and gave time to the patients.

Areas for improvement

Action the service SHOULD take to improve

The practice should fully implement its staff appraisal plan.

Care Quality Commission

Saxena Bowden Saxena

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager adviser as well as an expert by experience. An expert by experience is someone who has used health and social care.

Background to Saxena Bowden Saxena

Minden Family Practices is a group of three practices operating from the third floor of a purpose-built premises at Moorgate Primary Care Centre in the centre of Bury. All consulting rooms were on the first and second floors of the centre. The group as a whole serves around 19000 patients and provides a wide range of high quality services. The Anchor Practice is one of the three group practices with a current list size of approximately 5300.

The building complies with the Disability Discrimination Act 1995 (DDA). The consulting rooms are on the ground and first floors with lifts which are accessible for wheelchairs, disability scooters and prams. All corridors and doors wide enough to accommodate all types of disabled equipment. Minimal car parking is available on site which was not within the powers of the practice to change. The practice offers an open list and welcomes new patients living or moving to the area. New patients are accepted into each of the three practices on a monthly rota basis unless otherwise specifically requested.

Medical staff include a lead male GP and two female partner GPs who provide 19 clinical sessions per week. There is also a GP trainee. Services offered include chronic disease management, childhood vaccinations, six week baby assessments, travel vaccinations, smoking cessation services and drug dependency and counselling services.

A staffed reception service is available Monday to Friday from 8am until 6pm with full telephone access from 8am until 12.30pm and 2pm until 6pm daily. Between 12.30pm and 2pm the practice staff are only available for emergency calls. An automated telephone service was available to make appointments from 7am until 8am and from 6pm until 11pm on weekdays and from 7am until 11pm at weekends. This allows booking and cancellation of appointments. The Anchor practice does not currently offer extended working hours but patients are able to book an appointment to see a GP on a Saturday and Sunday or weekday evening in the Moorgate Primary Care Centre.

The practice have opted out of providing out-of-hours services to their own patients and information on how to access services at these times was available to patients on the practice website, in patient leaflets and over the telephone and in the patient leaflet.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. There were no previous performance issues or concerns about this practice prior to our inspection.

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

Detailed findings

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 5th May 2015. During our visit we spoke with the two GP partners and the GP trainee, the operations and IT managers, three nurses and a health care assistant and three reception staff. We spoke with nine patients and reviewed 26 CQC comments cards. We met with a representative of the Patient Participation Group (PPG) and observed how people were being cared for.

Good

Are services safe?

Our findings

Safe track record

The Practice had a system in place for reporting, recording and monitoring significant events which they logged in an on-line tool available to all staff. The practice also used a range of other information to identify risks and improve patient safety. These included national patient safety alerts, comments and complaints received from patients, an incident and accident book and feedback from staff across the practices. All staff we spoke with, clinical and non clinical, were aware of their responsibility to raise concerns which they could do through a form on the desktop of their computers. These were sent to and collated by the Operations Manager or GP Lead. The practice held regular clinical, managerial, governance and training meetings and we saw evidence in minutes of those meetings that events of significance were discussed. They had identified that a more robust system to share and document learning across the other practices within the Minden Group was required. Plans to hold regular joint significant event meetings were in place.

Learning and improvement from safety incidents

We reviewed the log of significant events on one of the GPs computers. We were also sent information by the operations manager prior to the inspection. The data was divided into clinical and non clinical events and data we reviewed included five clinical and two non clinical events of significance for the year 2014/2015. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. We saw evidence of action taken as a result, for example discussion with the pharmacy about a prescription error, and systems in place to reduce the error occurring again in the future. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Significant events were a standing item on the practice clinical meeting agenda and the practice also held regular learning and training initiative meetings where they considered different scenarios and what to do when things went wrong. When necessary events of significance were discussed at non clinical staff meetings where staff, including receptionists, administrators and nursing staff, were encouraged to raise concerns in a blame free culture.

Events of significance were also shared with the Clinical Commissioning Group (CCG) and the practice were aware of events, that should be reported to the Care Quality Commission (CQC).

Reliable safety systems and processes including safeguarding

There were systems in place to manage and review risks to vulnerable children, young people and adults. There was a safeguarding lead within the Anchor practice trained to the appropriate level 3 and a separate safeguarding lead across the Minden Group. All staff knew who they were and how to contact them when required.

We saw certificates of training for nurses who had attended safeguarding training at level 2 provided by the CCG and non clinical staff were trained in safeguarding awareness. Where training needs were identified these were factored in for the future. Staff we spoke to were aware of their responsibilities to raise any concerns and were able to describe situations where they would consider safeguarding to be appropriate. They knew how to recognise signs of abuse in older people, vulnerable adults and children. Up to date safeguarding policies and procedures, with clear details of lines of contact, were accessible on the desktops of all staff.

There was a yellow alert system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and/or missed appointments. There was also an internal messaging system where clinicians could message each other during consultations if they had any concerns and required support.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Only nursing staff acted as chaperones and those we spoke with were aware of their responsibilities including where to stand to be able to observe the examination. We were told that the GP usually recorded the attendance of the chaperone and we fed back that the chaperone should also record their attendance. Chaperones were offered to men and women during any physical or intimate examination.

Good

Are services safe?

Medicines management

The treatment room nurse lead was responsible for the seven fridges at the practice and their contents and temperatures which were monitored daily. A stock check was carried out every week and monitored appropriately. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. Regular weekly stock monitoring meant that medicines were not wasted. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice were registered as a designated yellow fever centre and appropriate documentation was securely kept for patients who were not registered at the practice and required vaccination.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. In January 2015 the practice discussed concerns about overprescribing and reviewed ways to reduce that and in March 2015 we saw discussion around changes from one medicine to another to improve effectiveness in patients taking it.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP or nurse prescriber 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.

Cleanliness and 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 and received annual updates. We saw that nurses attended infection control training provided by the local authority and were told that the infection control lead provided updates to staff when required. We saw evidence that the lead had carried out an infection control audit and identified actions were completed or to be completed. Minutes of practice meetings showed that the findings of the audits were discussed.

Each nurse was responsible for cleanliness within their own environment and the practice had introduced “walk arounds” to ensure that cleaning was maintained in all areas. An infection control policy and supporting procedures was available for staff to refer to. Staff we spoke to were knowledgeable about how to deal with spills in their areas and knew how to access policy and procedure in the event of a needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and staff and patient toilets.

Areas of the building which were not clinical were managed by NHS Property Services. We saw cleaning schedules which evidenced that cleaning was maintained. During our inspection we noted that one of the patient toilets required cleaning and on checking later in the day we saw that it had been cleaned.

Legionella testing was undertaken by Integral Cleaning and a report sent to NHS Property Services who managed the building. Regular checks were carried out in line with policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales,

Good

Are services safe?

spirometers, blood pressure measuring devices and fridge thermometers. The practice used piped oxygen in their treatment rooms and liquid nitrogen and we saw evidence to ensure that these gasses were regularly maintained.

Staffing and recruitment

The practice had a recruitment 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, and registration with the appropriate professional body. Staff we spoke to were able to describe the recruitment process although only one of the staff had been employed for under two years. Other staff had been employed in excess of ten, twenty and thirty years.

No one person was directly responsible for human resources issues. This had been identified by the practice as an area requiring improvement and plans were in place to address it. Individual team leaders conducted sickness absence reviews. The operations and IT managers were responsible for ensuring that nurse personal identification numbers were checked, hepatitis B status was kept up to date, Disclosure and Barring Service (DBS) checks were in place and medical indemnity insurance were current. Records reviewed showed that all these were either up to date or being actioned.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Nursing staff said they were still a few nurse hours down but the practice was well staffed and arrangements were in place to cover leave through rotas. Nursing staff said that nurses did not arrange time off together if at all possible in order to keep patients safe at all times. In the event of unplanned nursing staff absence patients attending baby clinics would be reduced by fifty per cent for safety reasons. Patients were aware of this arrangement and were happy with it.

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 annual and monthly checks of the building, the 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 was an identified health and safety representative.

There was an accident and incident book and staff knew where this was. Staff were aware of their responsibilities to report any accidents and remove any health and safety risks.

There were emergency processes in place for patients with long term conditions such as those whose health deteriorated rapidly. Advanced nurse practitioners held clinics for patients experiencing acute episodes. Treatment nurses gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. We also heard examples of how clinics were reduced to increase safety in times of unplanned staff absence.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice discussed medical emergency scenarios and what to do in certain situations, at learning and training initiative (LTI) meetings.

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. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. There were identified first aid leads at the practice.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

the practice. The practice followed the Bury (CCG) corporate guidelines together with the Minden business continuity plan in the event of a serious emergency that could affect safe patient care and treatment.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The nurses and advanced nurse practitioners led in specialist clinical areas such as diabetes, heart disease and asthma and were well supported by the GPs at each practice. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice had acknowledged that the GPs and nurses could work better together to support patients with diabetes and had put systems in place to do this.

National data showed that the practice was above or within average for most standards. However, data showed that the practice were high with referral rates to secondary and other community care services for all conditions. This had been identified as a system error and the practice were working with the Clinical Commissioning Group (CCG) to resolve it.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

We saw examples of several clinical audits that had been undertaken including different areas of prescribing. One audit in particular looked at certain medicines in patients with diabetes. The audit concluded that the practice needed to work more effectively for patients with this condition. A re-audit indicated that there was good improvement in the practice standards but they still fell below requirements. The practice have therefore promoted the idea of having a lead GP for the purpose of diabetic prescribing and are discussing further training for nurses at their appraisal. This showed us that the GPs monitored their working practice and the effects on their service and made changes to provide positive outcomes for their patients.

Other clinical audits were linked to medicines management information and safety alerts or undertaken as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines and the GPs acted on appropriate advice and guidelines.

The practice had a local scheme to improve identification and care of dementia patients and their families. They attended multidisciplinary meetings in relation to patients nearing the end of their lives and they received training about mental capacity, deprivation of liberty and patients' best interests. There was also an in-house protocol for the management of palliative care and a palliative care register. This meant that people at the end of their lives could be easily identified and the proper steps to manage their care could be put in place. Reception staff had recently undertaken training on palliative and end of life care delivered by the local specialist palliative care nurse.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory

Good

Are services effective?

(for example, treatment is effective)

courses such as annual basic life support. There was a good skill mix among the GPs which included specialist training in family planning, dementia, cardiovascular disease and rheumatology.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

The practice were behind with annual appraisals but had set up dates for the coming year which included personal development plans to identify and implement learning requirements. Training was discussed at a regular monthly nurse meeting where nursing staff looked at what they needed and who would benefit most from attendance. Learning was then disseminated via that person through the rest of the nursing staff. Staff we spoke to confirmed that the practice was very proactive in providing training and funding for relevant courses if requested.

Administration and reception staff were able to cover each other's roles and those we spoke with felt enabled to do this. A more recently recruited member of staff we spoke with confirm they had received induction, training and continuing support from other members of staff and always felt able to ask for help if and when required.

Working with colleagues and other services

Clinicians attended Friday lunchtime meetings which were held internally to update each other on disease management. Internal and external speakers provided education at these meetings. Quarterly palliative care meetings were held and attended by GPs, district nurses and specialist palliative care nurses to review patients on the palliative care register. We noted that the practice nurses did not attend these meetings.

The practice worked closely with the local out of hours provider and had access to their system where they could update a special notes page to share information about their patients. Information included prescribing advice, diagnosis and easily identifiable Do Not Attempt Cardiopulmonary Resuscitation Procedures (DNACPR) when appropriate, on patients reaching the end of their lives. This information sharing was continually being reviewed and improved.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The safeguarding lead attended safeguarding meetings with the CCG and fed back information to their colleagues..

Information sharing

With one of the reception staff we reviewed the clinical system used at the practice. They told us that staff were able to see all patients across all the Minden practices which helped with continuity of care and information sharing (as patients across all the practices attended appointments with the nursing staff) All staff were bound by the confidentiality code of the practice.

Staff used an internal messaging system to inform each other of alerts, actions required, or relevant information about patients. This meant that immediate action could be taken when required. For example if a patient was being seen by a GP, and required an immediate blood test, they could use the messaging system to relay information and send the patient down to the nurses for immediate review. This saved the patient having to make and wait for a separate appointment and provided quick results when required.

Letters, hospital discharges and other patient information was scanned into the patient record or downloaded from the local hospital system. Discharge letters were reviewed by the GPs and changes to repeat medication, follow up tests and reviews were arranged as appropriate. All information from the Out of Hours Service was sent electronically through their internal system.

All acute admissions arranged by the GPs were discussed with the accepting admissions officer. A transfer of care form was sent with the patient or faxed to the accepting clinician. The forms included information on the current

Good

Are services effective?

(for example, treatment is effective)

condition, significant past medical history, all prescribed medication in the past three months, drug allergies and intolerances, test investigations in the last three months and all contact details.

Referrals were managed mostly through the Choose and Book System and secretaries were able to speak to consultants and other hospital staff to chase referrals on behalf of patients and monitor receipt of any urgent information.

Consent to care and treatment

The practice had a very specific policy and protocol which provided explanation about mental capacity with guidance for staff. The policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 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 we spoke to told us they were treated appropriately by staff, were involved in decisions about their care and treatment and were given explanations. We discussed different scenarios with the nursing staff who were able to demonstrate their understanding of the different types of consent and how they would obtain it during treatment such as providing vaccinations or taking bloods. Alerts on the patient record or through the internal messaging system informed clinicians about registered carers or advocates who may be asked to articulate on a patient's behalf.

We saw that specific written consent was obtained from patients who attended to receive holiday vaccinations or for any minor surgery treatment. We saw that enough information was provided to enable them to make an informed choice.

Health promotion and prevention

Each patient over the age of 75 had been identified, informed of their named GP and invited for an annual health check. Patients on the admissions avoidance register had been given a dedicated telephone number and a print out of their care plan to keep with them to enable improved management of their care by other health professionals in the event of a crisis.

All patients were provided information about how to maintain a healthy lifestyle which included signposting to a range of support services. Information was available to patients through the practice website about long term conditions, common ailments and where and how to receive the most appropriate treatment.

The practice offered national screening programmes, vaccination programmes, long term condition reviews and health checks. Information was pro-actively provided to patients to stop the onset of any potential problems before they manifested into long term issues. The nursing team offered advice on weight management, smoking cessation, blood pressure and cholesterol checks.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. If a patient required any vaccinations relating to foreign travel they made an appointment with the practice nursing team to discuss the travel arrangements. This included which countries and areas within countries that the patient was visiting to determine what vaccinations were required.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff understood and respected people's personal, cultural, social and religious needs and took them into account when making appointments or discussing treatment. We saw that the practice had a mixture of patients with different beliefs and staff explained how they dealt with these. Male and female clinicians were available and chaperones were offered to protect patients and staff during intimate procedures. We saw that staff took time to interact with people who used services and included those close to them such as family and carers.

We observed that patients were treated with dignity and respect by reception staff who were considerate and helpful. Staff presented a professional attitude and received customer care training in 2012. The practice also discussed different scenarios at learning and training initiative meetings such as how to deal with a patient who became angry or abusive, unplanned staff sickness, patients' choice or beliefs and how to identify and report vulnerability.

We looked at data for the practice on patient satisfaction which included the 2015 national GP patient survey, a survey of patients undertaken by the practice in March 2014 and CQC comments cards. Results from the GP patient survey and comments from the CQC comments cards showed that patients were satisfied with how they were treated saying the GPs and nurses were responsive, gave them enough time and treated them with respect. Patients were happy that they had enough privacy and most consultations were carried out behind closed doors where conversations could not be overheard.

Care planning and involvement in decisions about care and treatment

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. 85% described their experience of the practice overall as good. 89% said the last GP they saw or spoke to was good at listening to them and 81% responded that they felt involved in decisions about care and treatment.

Patients we spoke with 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 were available for patients who did not have English as a first language and a hearing loop was available for people with hearing disabilities.

The GPs showed us evidence of care plans and patients' involvement in agreeing them.

Patient/carer support to cope emotionally with care and treatment

Staff told us that they made sure that patients understood them and encouraged them to ask questions at each consultation. They offered them alternative methods to help them understand their treatment such as leaflets and information downloaded from the internet. They signposted them to other services that could help them with emotional support, such as counselling and/or bereavement services, or support groups for mental health or other long term conditions. Nursing staff we spoke to showed us how they would do this and provided examples. Staff offered support to patients during times of bereavement. One patient told us of the bereavement support provided to them by their GP who they described as being very special and interested throughout a very difficult period.

We did not see any information in the patient waiting rooms which told patients how to access any other support groups or organisations other than a card offering mental health support services. The TV screen and patient website however told patients of a number of support groups and organisations. There was no information about support for carers available in the waiting room. However, GPs and nursing staff told us how they involved carers if and when required and that carers were noted on the electronic system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided evidence which showed that it was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice engaged regularly with the other practices in the Minden Group and with the Clinical Commissioning Group to discuss local needs and service improvements that needed to be prioritised. They also discussed minutes from the patient reference group (PRG) at their business meetings to see if any action was required. We saw that improvements to the appointment system had been adopted and this showed us that the practice were responsive to the needs of their practice population.

Tackling inequity and promoting equality

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

The premises and services had been adapted to meet the needs of people with disabilities. There was a suitable entrance at the front of the building for wheelchair use access, a lift and also disabled toilet facilities available. There was a hearing loop available. This is an assistive listening technology for individuals with reduced ranges of hearing.

We saw that the waiting area was large enough to accommodate patients with wheelchairs, mobility scooters and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing and breast feeding facilities.

Access to the service

A staffed reception service was available Monday to Friday from 8am until 6pm with full telephone access from 8am until 12.30pm and 2pm until 6pm daily. Between 12.30pm and 2pm the practice staff were only available for emergency calls. An automated service for making appointments was available from 7am until 8am and from 6pm until 11pm on weekdays and from 7am until 11pm at weekends. This allowed booking and cancellation of appointments. The Anchor practice did not currently offer extended working hours but patients were able to book an appointment to see a GP on a Saturday and Sunday or weekday evening in the Moorgate Primary Care Centre.

We reviewed the appointment system with the help of one of the reception staff in the afternoon. We saw that there was an available appointment that afternoon if required and ten other slots that afternoon which had been made available because of a bank holiday. The next available routine appointment was within five days. This was obtainable through the on line booking service but we were told it could be utilised in an emergency if required. Nurse practitioners triaged calls every day and appointments were available all day. We were advised that slots were added if necessitated by demand. This would mean that a same day appointment should always be available but was not the response received by all patients we spoke to.

Comprehensive information was available to patients about appointments 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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them such as those with long-term conditions, mental health issues or learning disabilities. Home visits were made by GPs and nurses, when appropriate and when required.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice several days before our visit and 26 patients chose to comment. All of the comment cards completed and all were complimentary about the service provided. Six cards mentioned long waits for appointments.

The practice had a complaints policy and procedure in line with recognised guidance and contractual obligations for GPs in England. There was designated responsible person who handled all complaints in the practice. If that person was unavailable to handle that complaint in a timely manner then the complainant would receive a holding letter stating when the complaint would be dealt with.

Most of the patients we spoke to said they wouldn't know what to do if they wanted to make a complaint but would ask for help if they needed to. Some were aware of the practice website. None had complained in the past or thought about complaining in the future. We saw however that patients were informed about their right to complain and how to do so which included information about external bodies of support such as advocacy services.

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 aimed to delivery high quality care and promote good outcomes for patients and this vision was part of the Minden Group strategy and ongoing business plan. Staff were encouraged to be part of this plan and were led by the GPs through Learning Time Initiatives (LTIs) and ongoing staff meetings. The GPs understood their areas of responsibility and took an active role in ensuring a high level of service was provided on a daily basis. All the staff we spoke with felt valued and felt that their views were included in how the service should be developed.

The proactive demonstrated that they were interested in the views of their patients and they did this through various areas of feedback such as the patient participation group (PPG), feedback forms, patient surveys and other questionnaires. Most of the staff had been employed for many years and the practice were proud of the staff knowledge of their patient group.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at many of these policies and procedures and which were up to date and had been shared with staff. Staff we spoke with said they knew where the policies were and how to access them when required.

The practice nurses told us about a local peer review system they took part in within the Minden Family Group which was supported by the GPs. We saw that they were able to discuss, review and support each other's clinical practice and identify training needs and areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Each GP carried out an audit to monitor performance as part of their annual appraisal. The practice had also run an Atrial Fibrillation audit and used risk assessment tools in their clnical system to monitor patients risk of disease.

Leadership, openness and transparency

There was a new leadership structure which was in its infancy but staff we spoke with said they knew who to go to with regard to different issues. For example they knew who the leads were in safeguarding, infection control, IT issues and practice issues. They reported that the management structure worked well although they said they would like someone "in between" who could be responsible for day to day management issues. The practice were aware of this and discussed that and other matters openly with all staff during LTIs. The practice also held regular governance meetings where performance, quality and risks were discussed.

No one person was directly responsible for human resources issues. This had been identified by the practice as an area requiring improvement and plans were in place to address it. Individual team leaders conducted sickness absence reviews. The operations and IT managers were responsible for ensuring that nurse personal identification numbers were checked, hepatitis B status was kept up to date, Disclosure and Barring Service (DBS) checks were in place and medical indemnities were current. Records reviewed showed that all these were either up to date or being actioned.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through patient surveys, comments and complaints and via the patient reference group (PRG). They valued and acted on feedback received and were actively trying to widen patient participation. We spoke to one member of the PRG who provided positive feedback reporting that the practice were supportive and tried to include patient views and make changes to improve services offered. We looked at the responses from patients who had completed the GP annual patient survey and friends and family tests. The practice had taken positive and negative results from the responses and were acting on ways in which to address the negatives.

We reviewed the minutes from the most recent PPG/PRG meeting which showed discussions about patients issues and ways to make things better. We saw actions for the practice to be taken away, considered and brought back to the next meeting. In January, because of feedback received through an appointment survey, the practice made changes to their appointment system and made more appointments available throughout the day. They also

Are services well-led?

Good

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

increased access to the advanced nurse practitioners and more importantly raised awareness of their role with patients who preferred to see a GP when it may not be necessary.

Practice staff were encouraged to provide feedback and meetings and learning time initiatives (LTIs) and they reported that they would not hesitate to speak up at any of these forums. They felt involved and listened to and provided evidence where their requests had been taken into account and actioned on. This included better cross working of administration and reception staff and better sharing of roles. Staff knew the term "whistleblowing" and said they would go to a peer or a manager to discuss any serious issues or concerns.

Management lead through learning and improvement

We looked at the staff training matrix. There was an acceptance by the management that some mandatory training had fallen behind but the proactive had now purchased an electronic training suite and were pro-actively encouraging staff to get up to date with all mandatory training. This included health and safety, infection control, information governance, fire safety and any other requested education appropriate to staff roles.

Practice nurses attended regular peer meetings where they identified training needs which were then supported by the GPs.

Personal development plans were currently being arranged for each member of staff and these would be reviewed annually. All staff we spoke with said the GPs were very supportive of training and were happy to attend LTIs which were interesting for all staff and talked about "hot topics" within the CCG. Recent topics of learning had included stroke management, psycho-sexual therapy, management of obesity in diabetes, prescribing, admission avoidance, case studies and a presentation by Bury Health Trainers.

The practice also used LTIs as "time out" for social events such as staff leaving parties.