Conran Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Conran Medical Centre on 22 June 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- The majority of patients we gathered information from on this inspection indicated they were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were thorough, professional and approachable.
- The practice offered a variety of pre-booked, emergency and on the day appointments, extended opening hours and weekend opening were planned for the near future.
- The practice provided a good standard of care, led by current best practice guidelines, which clinical staff routinely referred to.
- People with conditions such as diabetes, kidney disorders and asthma attended regular clinics to ensure their conditions were appropriately monitored, and were involved in making decisions about their care.
- The practice shared information appropriately with other providers, such as out of hours care providers, to ensure continuity of care to patients.
- The practice had good facilities which were kept safe, and were well equipped to meet patient need.
- The building was clean, and the risk of infection was kept to a minimum by systems such as the use of disposable sterile instruments.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

The areas where the provider should make improvements are:

- Ensure systems are effective to check and identify when emergency medicines and equipment have reached their expiry date, so that these are disposed of.
- Ensure additional training on the Mental Capacity Act is provided and improve documentation around consent and capacity issues.
- Ensure the recruitment policy is updated to include reference to mandatory pre-employment checks.

We saw areas of outstanding practice including:

- The practice focussed on patients who had recently been bereaved and trained staff to become bereavement champions. We saw specific examples of how patients had benefited from this approach.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough suitably trained staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. 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, improved methods of recording capacity and consent should be introduced. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked effectively with multidisciplinary teams and other services.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for most 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. Information to support patient's conditions was provided and GPs were willing to make ad hoc telephone calls to support patients. We also saw that staff treated patients with kindness and respect and maintained confidentiality. The practice had trained some of their staff to support bereaved patients; we saw examples of where this had been effective.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was proactive in initiating and becoming part of local projects to improve outcomes for patients. Patients said they usually

Summary of findings

found it easy to make an appointment with a GP or nurse and that there was continuity of care, with urgent appointments available the same day. The practice had very 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. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision with quality and safety and care as its top priorities. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and had an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Clinical staff 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 available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Self-empowerment was promoted so that patients could be more involved in their own health management and improvement.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Baby immunisation and children's clinics were held on a weekly basis.

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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, asylum seekers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and GP demonstrated sound knowledge around patients who lacked capacity to make their own decisions, although this could have been better documented.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and patients were referred to a memory assessment clinic when appropriate.

Summary of findings

What people who use the service say

We received 34 completed CQC patient comment cards and spoke with ten patients at the time of our inspection visit. We spoke with people from ethnic minority groups, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

We also looked at the results of the 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. For this practice 450 surveys were sent out with 116 being returned, giving a response rate of 26%. The survey showed that the practice was higher than average amongst practices in the area and nationally.

Areas for improvement

Action the service SHOULD take to improve

- Ensure systems are effective to check and identify when emergency medicines and equipment have reached their expiry date, so that these are disposed of.
- Ensure additional training on the Mental Capacity Act is provided and improve documentation around consent and capacity issues.
- Ensure the recruitment policy is update to include reference to mandatory pre-employment checks.

Outstanding practice

- The practice focussed on patients who had recently been bereaved and trained staff to become bereavement champions. We saw specific examples of how patients had benefited from this approach

Conran Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors; a GP and a practice Manager. Our inspection team also included an Expert by Experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Conran Medical Centre

Conran Medical Centre provides primary medical services to approximately 5,000 patients in the catchment area of Harpurhey and surrounding rural areas. Services are provided from a purpose built building just off the main A664 Rochdale Road under a General Medical Services (GMS) contract.

There are two GP partners and one salaried GP, and patients can be seen by a male or female GP as they choose. There is a team of 3 nursing and healthcare assistant staff. They are supported by a team of management, reception and administrative staff.

Out of Hours services are provided through GoToDoc. The practice has recently formed an alliance with nine other practices in the area, under the banner of the North Health.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Detailed findings

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We carried out an announced inspection on 22 June 2015. During our visit we spoke with two GPs, one nurse, a health care support worker, the Practice Manager and reception staff. We also spoke with a member of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the practice.

Good

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at minutes of team meetings and confirmed that significant events and incidents were discussed and appropriately progressed. We noted that clinical and non-clinical staff were able to describe a number of significant events and how they had been investigated. Management accepted that some more minor incidents could have been better recorded and that some learnings may have been missed.

The practice had a system for dealing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and sent to the clinical staff for their information.

Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Significant events and changes to practice were discussed with practice staff. Action was taken to reduce the risk of recurrence in the future. The GPs completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. The Practice Manager told us that regular informal clinical meetings were held and that full staff meetings always took place monthly. We looked at the minutes of these meetings and saw that they were well attended and clearly documented.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the partner GPs took the lead role for safeguarding children and adults. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required. We saw a number of examples of effective engagement with safeguarding issues and it was clear that the practice took its responsibilities very seriously. We were told that the patient list included a large numbers of patients living in deprived circumstances, which led to regular safeguarding concerns being raised.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3 for children) safeguarding training for those with key safeguarding roles was provided. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Staff were familiar with the procedures around whistle blowing. All staff had also recently undertaken training in recognising and effectively dealing with patients who may have been subject to domestic abuse.

Practice nurses, health care assistants (HCAs) and some reception staff were available to chaperone patients who requested this service and information about this service was available in the waiting area. Staff had been trained in how to chaperone. When we spoke to staff they told us that they were confident in performing a role as a chaperone, and told us that the GPs would always explain in full to the patient what they were doing and why. There was a chaperone policy for staff to refer to.

Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of one of the practice nurses. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the practice internal systems. Prescription security was effective. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. We noted from data that the practice had higher than average levels of prescriptions for hypnotic medicines. The practice had already recognised this and was tackling the issue, which was a historic one, caused by a different prescribing regime many years ago. In order to

reduce the levels prescribing of these types of drugs, they were not routinely repeated and patients were required to attend the practice for a review and a discussion about other options.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We saw that there were purpose built fridges all kept in locked rooms, equipped with locks and devices for monitoring maximum and minimum temperatures. We saw that systems were in place to check temperatures of the fridges and the stock contained within them was within date. We discussed the methods used for checking and maintaining appropriate levels of stock. The Practice Manager told us they intended to introduce a new documented system to assist in ensuring that stock was managed effectively. A cold chain policy was in place at the practice and staff were clear on the process for dealing with temperature sensitive medicines.

Cleanliness and infection control

We found the practice to be clean at the time of our inspection and patients we spoke to confirmed that this was always the case. Systems were being developed for managing infection prevention and control. We saw that an audit relating to infection control had been completed by the CCG with good results. One of the nurses was appointed as the lead for infection control and was developing an audit regime to compliment the work completed by the CCG. We spoke to the Practice Manager about reviewing and updating the infection control policy, they told us it was currently being done and the lead nurse would attend enhanced infection control training the near future. All clinical staff had already undertaken training in infection control.

We saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and there was a protocol in place. A receptacle in the waiting area was available for patients to leave any samples that required analysis.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques, some toilets were missing these signs and we were told that this would be addressed.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use; were fixed to walls and were positioned out of the reach of small children. Some toilet areas required pedal operated waste bins; the Practice Manager told us this would be addressed.

Equipment

A new contract had been arranged for annual checks of fire extinguishers and calibration of equipment such as scales and blood pressure monitors, some of these were two months overdue. There was a system in place for the scheduling the testing of portable appliances (PAT) of non-clinical electrical items, for example kettles, printers and computers, we checked a number of these and all had been tested appropriately. Documentation evidenced that other equipment in use was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not. We looked at medical equipment at the practice which was in readiness for use and found that all other than a two items were within the manufacturers' recommended use by date. The Practice Manager told us that they intending making an inventory of all equipment so that it could be better managed and monitored.

Staffing and recruitment

The provider recruitment policy was in place; however it required some updating so that it included reference to employment checks that are legally required before a new member of staff can start work. We looked at staff files and saw all of the employment checks that were required to be carried out had been completed. The GPs had regular

checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses and receptionists who carried out chaperoning duties also had disclosure and barring service (DBS) checks completed. Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Any sickness was closely monitored and return to work interviews were routinely completed. Support was given to staff where possible when they required it with issues related to sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. Staff told us that teamwork was very good at the practice and that this ethos continued throughout the management structure.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy this and all other practice policies were available to all staff at any time via a shared area on the practice computers.

Arrangements to deal with emergencies and major incidents

Basic life support training was completed annually with all staff; the practice did not have a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been scheduled, two fire Marshalls had been identified and fire alarm tests were completed regularly.

We saw appropriate emergency equipment and emergency drugs were available and staff knew where these could be located. We saw no evidence that emergency drugs and equipment were regularly checked to ensure it was operative and within the manufacturer's recommended usage date. We spoke to the Practice Manager about this and were told checks did take place and that would be better documented in future. We found one box of emergency medicine which had passed its expiry date. The GPs did not carry emergency drugs when carrying out home visits to patients, we discussed this with one of the partner GPs and the Practice Manager, they said they would review this decision at the next practice meeting with a view to either starting to carry such medicines or documenting a rationale why they do not.

A documented contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services; this plan was also available using a mobile telephone application. Staff we spoke with were aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and HCAs. Cardiovascular, Diabetes and other regular health checks and screenings were on-going in line with national guidance.

The practice had a system for reviewing patients with specific conditions. The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included chronic obstructive pulmonary disease (COPD), asthma, diabetes, heart disease, and dementia. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs.

Care plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and chronic kidney disease (CKD). We reviewed a sample of these care plans and saw they were detailed; patient centred and could be used by other health professionals to make informed decisions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us they supported all clinical staff to continually review and discuss new best practice guidelines.

Multi-disciplinary meetings were held regularly to discuss individual patient cases to ensure that all treatment options were considered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

This practice had achieved consistently high scores for QOF over recent years in most area which demonstrated they provided good effective care to patients. In the areas where scores were lower in 2013/14, such as identification of diabetes, the practice was able to show a significant improvement for the current year. The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. QOF information indicated that patients with long term health conditions received care and treatment above the national average.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG audits. One audit we looked at conducted by one of partner GPs was around cervical smears, the audit, the examination of results, the changes made and the re-audit indicated that a 10% improvement was made on samples taken.

The practice confirmed that peer review of clinical decision making was completed on a regular basis in clinical meetings, during case discussions at palliative care meetings, during reviews of admissions avoidance and by ad hoc discussions. One of the GPs and the Practice Manager told us that they intended to better document peer reviews in order that they were more visible and accessible for future reference.

The GPs, nurses and HCAs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as end of life care, and safeguarding. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

All the staff we spoke to at the practice were very complimentary about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice. The HCA had previously been a receptionist, they told us how they were encouraged to develop professionally and were afforded protected time to complete their qualifications.

Some reception staff were long serving and they knew the regular patients well, those who had some to the practice more recently had quickly fitted in and were seen as valuable assets by their peers and managers. There was an induction process for any new staff which covered areas such as the introduction to policies and procedures, confidentiality and health and safety issues.

All GPs were up to date with their yearly continuing professional development requirements and had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients. The practice had dedicated members of staff for updating information on systems and electronically capturing associated documents. One of the newer members of staff had suggested coding patient's information in a different order for improved availability of information, this has been trialled and introduced once the team recognised the benefits.

Information sharing

GPs met regularly with the practice nurses and the Practice Manager. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. Regular meetings involving all team members kept staff up to date with current information around enhanced services, requirements in the community and local families or children at risk.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Manager regularly attended area practice managers meetings to share information about their role discuss best practice and maintain their professional knowledge.

There was an informative practice website with information for patients including signposting, what clinics were available and prescription information. There was a patient participation group (PPG) established at the practice. We spoke to the chair of the PPG and they told us that the practice communicated effectively with the group, they had some ideas about improving the sharing of information with patients which they were going to introduce, for example a newsletter. We saw that the practice had acted on suggestions that the PPG had made, for example the introduction of a board with staff members names and photographs on.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers so that clinicians were aware that consent to treatment may be an issue for consideration. No consent policy was in place at the practice and staff had

Good

Are services effective?

(for example, treatment is effective)

not received formal training in the Mental Capacity Act. The Practice Manager told us that this would be resolved as soon as possible and we established that due regard was already being given to issues around consent, but had not been documented..

The 2015 national GP patient survey indicated 88% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 87% said the last GP they saw or spoke to was good at involving them in decision making and 93% had confidence and trust in the last GP they saw or spoke to. These percentages were above the average for the area.

Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse or the HCA. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. Where there were issues identified that required more detailed consultation, then patients were referred to one of the GPs.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. The practice had plans in place to introduce a blood pressure and weight machine for patients to use themselves whilst at the surgery.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to 10 patients in person and received feedback from 34 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the nurses, the reception staff and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room and a chaperone service was offered. Staff had received training on how to be an effective chaperone. When we spoke to staff about carrying out their chaperoning, they were confident about how to best perform the role.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in information security, equality and diversity, safeguarding children and adults and information governance. We also noted that there were practice policies to cover all these areas which staff could access via a shared area on the practice computers.

We looked at the results of the 2015 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 87% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 91% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were higher than those for most other practices in the area.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians, the practice website and prominently displayed in the waiting areas. The practice manager told us that they would like to review the way information was laid out in the waiting area so that it was better grouped. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Some of the GPs and reception staff spoke languages other than English, for example Urdu and Hindi. We were told and could see from data we held that there was a wide variety of minority ethnic groups in the area.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2015 GP patient survey reported that 87% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 92% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments. These percentages were higher than most other practices in the area.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or a vulnerable person. We saw there was written information available for carers to ensure they understood the various avenues of support available to them.

One of the GPs took the lead for palliative care. The practice maintained a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We looked at minutes of these meetings and saw that they were well written and comprehensive. Patient care plans and supporting information informed out of hours services of any

Good

Are services caring?

particular needs of patients who were coming towards the end of their lives. The practice had invested in training some staff to be bereavement champions and supported recently bereaved patients by telephone calls and sympathy cards as well as supporting them personally. The practice was introducing a bereavement support group which was being facilitated by one of their patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, Practice Manager meetings, local area team meetings and meetings with Macmillan and district nurses. The practice had a tablet device in the reception area so that patients could more easily record their views via the friends and family test.

Patients were able to access appointments with a named doctor and all patients over 75 had a named GP. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP. We saw evidence that the GPs made as much use as possible of the time produced by people failing to attend appointments and a system was in place to deal with repeated failures to attend appointments. Longer appointments could be made for patients such as those with long term conditions or with more than one condition they wished to discuss. Clinical staff regularly conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews. A documented system was in place to ensure that people who required regular reviews were contacted and a suitably long appointment was scheduled in order to meet their individual needs.

Conran Medical Centre had a reception area and sufficient consultation and treatment rooms. There were also facilities to support the administrative needs of the practice (including reception offices, Practice Manager's office and meeting rooms). The building was easily accessible to patients including those with a disability. We noted there was no hearing induction loop available for patients who may require one; this was an issue that the practice had identified and had included in its current planning.

Tackling inequity and promoting equality

The practice had taken steps 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 service that was individualised and responsive to individual need 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.

The practice provided information for people whose first language was not English as well as interpreter services. There were good communication links with services for vulnerable patients, this assisting in gathering information on the medical requirements of these groups of people. Asylum seekers were able to register at the practice and receive the same levels of care as any other patient on production of appropriate documentation.

Access to the service

There were a number of ways of accessing appointments including an on line appointment service which the practice was currently promoting as the take up had been disappointing. We looked the results of the 2015 GP survey 88% of respondents found the receptionists at the practice helpful, 97% of respondents said the last appointment they got was convenient and 88% of respondents described their experience of making an appointment as good. These percentages were similar or higher than most other practices in the area and nationally.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

information pack given to all new patients. The practice was open every day 8.30am to 6.00pm and closed on Wednesday afternoons. The practice had been chosen to host the neighbourhood hub, where appointments at the practice would be available until 8pm each day and for two hours at weekends. This arrangement meant that appointments would be available for all patients registered with the local practices in the hub. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

GP appointments were provided in 10 minute time slots and were pre bookable; longer appointments were available for patients with more than one issue for discussion. Appointments could be accessed by telephone, in person or on line. Urgent appointment slots were kept available throughout the day with one of the GPs always 'on call' during surgery hours. Telephone consultations were used when appropriate. Two female and one male GP were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The Practice Manager told us that they were constantly reviewing patient demand and appointment availability, responding to it by altering the patients booking system to ensure it was always effective. The practice operated an effective referral system to secondary care (hospitals).

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Practice Manager was the designated responsible person who handled all complaints in the practice. Staff we spoke to were confident in dealing with complaints at reception or during surgery and would always inform the practice manager about the complaint and its nature so that it could be dealt with at the appropriate level.

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint and felt confident in doing so should the need arise.

In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We saw that complaints had been reviewed so that any learning and potential improvements could be identified. Complaints and significant events were discussed at regular meetings.

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

There was a clear leadership structure at the practice and staff were aware of how the management structure operated and their responsibilities. Each of the GPs had specialist skills or areas of interest which were known to staff and shown on the practice website. GPs were able to share their knowledge with the rest of team and this had proved effective in helping staff professionally develop. Nursing staff with whom we spoke told us how there was excellent team work and how GPs were always ready to provide advice and guidance on clinical matters. We were told by all the staff at the practice that the Practice Manager was particularly effective.

We saw that the practice had a mission statement to its patients: "We strive to offer our patient's choice to access a wide range of quality medical services. We believe that health care is a team effort and will work in partnership with our patients and staff to provide the best primary care services possible, working within local and national governance, guidelines and regulations. In an increasingly complex society we place a high value on the need to respect patient confidentiality in all age groups. Above all we aim to make the surgery environment as relaxed and friendly as possible without compromising overall efficiency." We asked staff about the statement and they were clear on what they were trying to achieve as a practice and how each of them contributed to the overall aim.

Governance arrangements

The practice held regular documented meetings for clinicians and management. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing mostly at or above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. We saw evidence that showed the GP and Practice Manager met with the CCG on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. The practice employed a staff member dedicated at looking at data quality and QOF.

The practice had a system in place for clinical audit cycles; we saw several examples of these having taken place. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits.

Leadership, openness and transparency

Staff told us that felt valued and well supported and knew who to go to in the practice with any concerns. The reception team had worked together for several years and had been afforded opportunities to develop both within their role and into clinical roles. They told us that staff tended not to want to leave once they started working at the practice such was the level of job satisfaction, this was reflected in the low levels of staff turnover. The culture at the practice was one that was open and fair and this was very apparent when we spoke to staff. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw staff undertook annual appraisals and these were completed in a timely manner. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. The practice had a clear and effective business plan which was aimed at improving services for its patients.

The Practice Manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and health and safety, which were in place to support staff. Staff we spoke with knew where to find these policies if they required them for review.

We were told that support for learning, development was very good. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the Practice Managers. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions. We saw examples of staff members making suggestions which had later been implemented.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient satisfaction surveys (last completed September 2014), comment cards and complaints received. We looked at the results of the 2015 GP patient survey it reflected high levels of satisfaction with the care, treatment and services provided at Conran Medical Centre.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. They told us that the practice was very supportive of them accessing training relevant to their role and personal development.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with all staff during meetings to ensure outcomes for patients improved. We noted that the practice was very open and transparent in sharing any errors and issues of concern.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. All clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.