Dr S A Chacko & Dr R E Hubber --- Peel GPs

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Chacko and Dr Hubber on the 5 May 2015. We found that the practice was performing at a level which led to a rating judgement of good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed, and care was planned and delivered following the best practice guidance. Staff had received training appropriate to their roles, and any further training needs were identified and planned.
- Baby clinics were timed to run alongside health visitor clinics within the building. This provided maximum convenience for families and maximised on immunisation rates.
- Patients said they were treated with compassion, dignity and respect, and they were involved in their care and decisions about their treatment.
- Information about how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment, that there was continuity of care, with urgent appointments available the same day.
- The practice was part of the Easy GP Scheme run by Bury GP Federation. This gave patients access to routine pre bookable and same-day GP appointments at four sites across the Bury area from 8 am to 8 pm Monday to Friday and 8 am – 6 pm at the weekend.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff worked with local services Bury Drug and Alcohol Team to support patients with addiction. A drug counsellor attended the practice to see patients once a week, and a GP from a neighbouring practice provided specialist support for these patients.

Summary of findings

- There was a clear leadership structure that focussed on the care and treatments provided to patients. The leadership was proactive in using methods to improve patient care and improve service provision. Staff felt supported by management. The practice proactively sought and acted on feedback from staff and patients.
- The practice works closely with and supports the provider of the “zero tolerance” scheme and would take registration from patients removed from previous practices for violent or aggressive behaviours. This supported these patients to access the service when in need of medical care.

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

Also, the provider should:

- Provide information in the patient waiting area in different languages to support patients whose first language is not English
- Ensure medicines are stored securely.
- Ensure GPs receive training on the Mental Capacity Act and Deprivation of Liberty Safeguarding.

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. This practice was safer and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned from internal incidents and communicated widely to staff to support improvement. Information about safety was highly valued and risk management was comprehensive and recognised as the responsibility of all staff. There were enough staff to keep patients safe. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We saw evidence confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Patient's needs were assessed, and care was planned in accordance with patients' care needs. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles, and any further training requirements had been identified and planned to meet these needs. Staff worked with multidisciplinary teams to ensure patients' care needs were identified and planned for.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently positive. We observed a patient-centred culture at the practice. Patients said they were treated with dignity and respect, and they were involved in decisions about their care and treatment. Information to help patients understand the services was available and easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing a responsive service. Most patients told us it was easy to get an appointment with their choice of GP, and urgent appointments were 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 the practice responded when

Summary of findings

issues were raised. Learning from complaints was shared with staff. The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements when identified.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision of quality and safety as its top priority. The strategy to deliver this vision 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 were reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients. Staff had received induction training and regular performance reviews and 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. The practice gave all patients over 75 years of age a named responsible GP. The building was fully accessible for patients who have mobility problems. Staff were alert to and made adjustments where possible for patients with sensory disabilities. For example, a hearing loop was available and assistance dogs were welcomed. Reception staff would escort patients who experience mobility problems to consultation rooms when needed. Staff were proactive in offering Influenza and shingles vaccinations to patients over 65 years. If patients became housebound timely home visits were offered. GPs and clinical staff worked at a local nursing home under the local enhanced services scheme. They completed a weekly visit to see all patients to address their care needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions.

A robust recall system for annual reviews and other monitoring for patients with chronic diseases and long term conditions was in place. Clinical staff were up to date with management and monitoring of long term conditions. GPs ran regular chronic disease clinics in addition to the appointments offered by the practice nurses. The practice also used clinical software Vision Plus to opportunistically review chronic disease monitoring and management. Patients whose long term conditions left them at increased risk of hospital admission were covered by the Unplanned Admission Enhanced Service. They had care plans in place with quarterly reviews and post discharge reviews. The practice was proactive in offering flu vaccination to those eligible or in at risk groups.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. GPs had recently reviewed and improved the provision of child health surveillance. A newly designed welcome pack was available to families of new babies registered with the practice. The practice offered a 'one stop' clinic for the 6/8 week check. First immunisations and postnatal appointment for mothers and baby clinics were timed to run alongside health visitor clinics within the building to minimise the number of appointment attendances for the family. Baby changing facilities were available along with a room that could be used for breastfeeding. The practice

promoted national and local immunisation campaigns. The telephone triage system ensured children were seen quickly, and for parents and carers to have access to medical advice in a timely fashion. The practice offered a full range of family planning services on site including implants and coils. Midwife appointments were available at the practice. Clinical staff engaged with other agencies for safeguarding purposes and all staff were up to date with safeguarding training and were aware of when and how to get further advice. Appointments for immunisations were available to fit around school times. Children's attendance at A&E was monitored. Surveillance of A&E discharge summaries as they enter practice were acted upon where necessary. The A&E discharge summaries were always sent automatically to health visitors who were proactive in identifying such concerns.

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 practice nurse and health care assistant appointments were available from 8 am and routine GP appointments were available to pre-book in advance from 8.30am. Prescriptions and online appointments were bookable 24 hours a day. The telephone triage service ensured a flexible appointment system. The practice was part of the Easy GP Scheme run by Bury GP Federation. This gave all patients access to routine pre bookable and same-day GP appointments at four sites across the Bury area from 8 am to 8 pm Monday to Friday and from 8 am to 6 pm at the weekend. NHS health checks were actively promoted for newly registered patients and patients already registered at the practice.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. All staff kept up to date with current safeguarding guidelines (adult and child). A record was kept of patients who may be seen as being vulnerable. For example patients who may misuse substances, patients involved in domestic violence or patients with mental health problems. Patient confidentiality was maintained. GPs attended inter-agency meetings such as vulnerable adult meetings. Reception staff were alerted by red flags on the IT system about patients who had failed to collect prescriptions regularly with clinical staff being notified where appropriate. Patient information leaflets were readily available regarding child and adult safeguarding issues. Clinical staff worked with local Bury Drug and Alcohol services. Patients with a learning disability, together with their carers, were offered an annual review with a 30 minute appointment.

Summary of findings

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 telephone triage service allowed for a quick response for patients who felt their mental health was deteriorating, or they were at crisis point and longer appointments were available to these patients. Annual reviews were held for patients with complex mental health needs, with care plans being put in place as appropriate. GPs engaged with a local dementia diagnosis and management enhanced service which meant more patients could be diagnosed and managed at the practice by familiar GPs rather than going to secondary care. The practice offered and invited all patients with dementia for an annual review and physical health check. Through a local enhanced service, the practice cared for the majority of patients in a local nursing home. These were predominantly patients with a history of dementia. Weekly review visits were offered to any patient needing care. Patients' care plans and planning for end of life care was reviewed annually or as necessary.

Summary of findings

What people who use the service say

We looked at 16 CQC comment cards that patients had completed prior to the inspection and spoke with seven patients. Patients were very positive about the care they received from the practice. They commented they were treated with respect and dignity and described the staff as very good and helpful. Patients spoken with told us they had enough time to discuss their care needs during consultations and that clinical staff explained their treatments and the risks involved. They said they felt listened to and involved in decisions about their care.

The comments on the cards provided by CQC were also very complimentary about the staff and the service provided. They described the service as perfect and outstanding. They said the staff were very caring, pleasant and professional. Patients commented they were always treated with respect, and the GPs were excellent, very caring and understanding. Overall they were very happy with the standard of care and treatment they received.

The National GP Patient Survey in March 2014 found the following:

75.6 % of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care.

87.69 % of respondents to the GP patient survey stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care

82.9 % of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern.

39.23 % of respondents to the GP patient survey stated that they always or almost always see or speak to the GP they prefer.

These responses were about average when compared to other practices nationally.

We looked at the Friends and Family test carried out by the practice in April 2015. This patient survey asked patients how likely they were to recommend the surgery/ services to friends and family. Eight comment cards were completed. They all indicated they were extremely likely to recommend the practice to family and friends. Comments indicated that patients were extremely happy with the service they received and considered the staff to be professional and caring.

Areas for improvement

Action the service SHOULD take to improve

Action the provider SHOULD take to improve:

- Provide information in the patient waiting area in different languages to support patients whose first language is not English
- Ensure medicines stocks are stored securely.
- Ensure GPs receive training on the Mental Capacity Act and Deprivation of Liberty Safeguarding.

Dr S A Chacko & Dr R E Hubber --- Peel GPs

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector led our inspection team. The team included a GP and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services.

Background to Dr S A Chacko & Dr R E Hubber --- Peel GPs

Dr S A Chacko & Dr R E Hubber surgery is based in Bury, Greater Manchester. The practice treats patients of all ages and provides a range of medical services. The staff team includes two GP partners, two practice nurses and a healthcare assistant. The administration team consists of the practice manager and 12 administrative and reception staff.

The practice is open Monday to Friday from 08.30 to 18.00. Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre bookable consultations, same day (advanced access) appointments and home visits to patients who are housebound or too ill to attend the practice. The practice closes one afternoon per month for staff training. When the practice is closed patients access BARDOC the out of hours provider.

The practice is part of Bury Clinical Commissioning Group. It is responsible for providing primary care services to approximately 3,300 patients. The practice has a General Medical Services (GMS) contract.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before our inspection, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 5 May 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how the staff handled patient information, spoke to 2 patients face to face and carried out five telephone interviews. We discussed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We looked at survey results and reviewed CQC comment cards left for us on the day of our inspection. We spoke with the practice manager, registered manager, GPs, practice nurse, administrative staff and reception staff on duty.

Good

Are services safe?

Our findings

Safe track record

Bury Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. Clinical staff told us they completed incident reports and carried out significant event analysis (SEA) to reflect on their practice and identify any training or policy changes. Clinical and non-clinical staff told us they felt able to report significant events. They said the incidents were analysed, learning points identified and changes made to practice as needed. We looked at a sample of significant event reports and saw that a plan of action had been formulated following the analysis of the incidents. Documentation was very detailed with evidence of learning disseminated at clinical meetings. We spoke with the trainee GP (FY2). They confirmed they had not been involved in any SEA to date. They said they felt confident to speak to either of the GPs if any significant events had occurred. The trainee GP attended practice clinical meetings where SEA were discussed in a very open culture of learning and sharing of information. This showed the practice had managed SEA consistently and so could show evidence of a safe track record about patient care needs.

Alerts and safety notifications from national safety bodies were managed by the practice manager and disseminated to clinical staff regularly. This ensured they kept up to date with changes to care practices. Staff confirmed that they were informed about and involved in any required changes to practice or any actions that needed to be implemented.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents.

Lessons were learned, and improvements made when things went wrong. For example, a pattern of prescribing errors was identified involving prescriptions of sedation medicines. Errors were identified as being related to the automatic template being generated on the electronic system. As a result of this, staff had changed prescription system on the template so that this medicine appeared as a default when this was appropriate. This work demonstrated that patients were treated in accordance with best national guidance.

Staff were kept fully informed of the outcome of any safety related investigations for the purpose of learning and improving service provision. They were able to describe the incident reporting process and told us they were encouraged to report incidents. They told us they felt confident in reporting and raising concerns and felt they would be dealt with appropriately and professionally.

Reliable safety systems and processes including safeguarding

The practice was able to identify the things that were most important to protect people from abuse and to promote safety. A proactive approach was taken to safeguarding. Effective safeguarding policies and procedures were in place and were understood and consistently implemented by staff. Staff had access to the safeguarding policies and procedures for both children and vulnerable adults. This provided staff with information about identifying, reporting and dealing with suspected abuse. Staff spoken with confirmed they had completed training in safeguarding at a level appropriate to their role, and they demonstrated knowledge and understanding of safeguarding and its application.

One of the GPs took responsibility for managing safeguarding issues. They were trained to the appropriate level that ensured safeguarding matters were managed correctly, and patients were protected from harm and abuse. They also kept up to date with online training modules and worked closely with a neighbouring practice that readily provided advice as needed. Staff spoken to were aware of the lead GP in this area and who to speak to in the practice if they had a safeguarding concern. The GPs engaged with other agencies as necessary for safeguarding purposes. Safeguarding issues were discussed during clinical meeting with written documentation kept for the purpose of auditing and monitoring that the issues were being managed correctly. This meant that there were robust systems and processes in place to safeguard the patients who used the service. Arrangements were in place for monitoring patients who were vulnerable. This was also done on an ad hoc basis working with health visitors when vulnerable children were identified. GPs worked together around decision making, and there was a close collaborative working with a neighbouring practice. A register was kept of any issues raised relating to individual patients and alerts were placed on their notes as needed.

Good

Are services safe?

The practice had recently reviewed and improved the provision of child health surveillance. The telephone triage system ensured children were seen quickly and for parents and carers to have access to medical advice in a timely fashion.

There was a system in place for children's attendance at vaccination clinics. One of the GPs took responsibility for this area of work. A 'one stop' service was offered where post natal mothers and vaccination checks carried out in one clinic so reducing the amount of patients who do not attend these clinics. This resulted in an excellent response for children who were not immunised. Parents who did not attend these clinics were recalled for a second appointment.

Children's attendance at A&E was monitored. Surveillance of A&E discharge summaries as they enter practice were acted upon where necessary. The A&E discharge summaries were sent automatically to health visitors who were proactive in identifying such concerns.

The practice had established systems in place to record A&E paediatric admissions. Discharge summaries were automatically sent to health visitors which provided a safety net in case the matter resulted in a safeguarding concern.

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 trained clinical staff, usually nurses or health care assistants acted as a chaperone. A GP would also act as a chaperone if nurses were unavailable.

Medicines management

Temperature logs for the vaccine fridge were accurate and complete. The fridge temperatures were calibrated at least every month, but the information was not recorded. Fridges were only used for storing vaccines. There was a system of stock rotation in place to ensure they were used in line with current guidelines. Staff were trained to give vaccinations and supporting guidelines were in place.

Clinical staff were responsible for ordering medicines, and a check was made of the medicines when they were delivered to the practice.

Both GPs had a doctors bag that held minimal medicines. Practice nurse kept a log of expiry dates each month. Prescriptions were stored securely. They were numbered so they could be audited properly, and there was a clear audit trail for the authorisation and review of repeat prescriptions. Prescriptions that were not collected were kept for three months and then disposed of. An alert was placed on the IT system for that patient to record their medicines had not been collected.

The practice received regular medicines management alerts from the Clinical Commissioning Group. As a result of this, patients' medicines were audited with changes made to reflect the information identified in the alert.

The patients spoken with said they were happy with the way their prescriptions were handled and patients who used repeat prescriptions said the system in place worked well. Two patient comments cards we received made reference to the way their medicines / prescriptions were managed. One indicated they were always given repeat prescriptions they had not asked for and the other said their medicines were regularly reviewed, and they were happy with this arrangement.

A recall system was used to review patients' medicines, for example, patients newly diagnosed with depression to ensure that these patients do not lapse for more than six weeks before being reviewed again. Patients' medicines were regularly reviewed and more often if there was an identified risk. A recall system was in place if patients did not attend the review appointments

Controlled drugs were closely monitored by GPs, and a policy was in place for the management of some medicines for patients who were at risk of overdoes or misuse. In these circumstances, links with local drug teams were established for the issuing of prescriptions.

Cleanliness and infection control

Patient feedback on the CQC comment cards we received was very positive about the standard of cleanliness throughout the building.

There were effective systems in place to reduce the risk and spread of infection. The consulting rooms were clean and well maintained. There was hand washing facilities in each of the rooms. The appropriate hand washing procedure was displayed over the sinks and hand wash was available.

Good

Are services safe?

Equipment such as disposable gloves and aprons were available. These items were readily available to staff in the consulting and treatment rooms. Sharps boxes were available for the disposal of needles. Sharps bins were appropriately located and labelled. The practice had spillage kits so staff could effectively deal with any spillage of body fluids. Clinical waste and used medical equipment were stored safely and securely before being removed by a registered company for safe disposal.

An infection control audit was undertaken 18 months ago by the local NHS Trust. A small number of areas were identified that required further attention. We were informed these issues had been addressed. We were informed that an infection control audit had not been done since this time and arrangements were being made to address this.

Staff were trained in infection control procedures and a policy was available for guidance. This meant that appropriate measures had been taken to ensure patients and staff were being protected from the potential spread of infection.

Equipment

The practice had the equipment they needed for the care and treatment they provided. There were service contracts in place for regular checks of fire extinguishers, and the calibration of medical equipment such as blood pressure monitors, baby scales and ear syringes. Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. Small electrical appliances were tested for their safety.

Staffing and recruitment

The staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The practice worked closely with two other practices in the building and an arrangement was in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and sickness to ensure the staffing levels were maintained to a safe level.

Staff records reviewed contained evidence that appropriate recruitment checks had been undertaken prior to staff being employed. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 medicines management and infection control. The practice used an IT record system that was password protected. Health and safety information was displayed for staff and fire drills took place.

Older patients who became housebound were offered timely home visits, and there was a robust recall system for annual reviews and other monitoring for patients with chronic diseases and long term conditions. The practice nurses were up to date with management and monitoring of long term conditions. Patients with a learning disability, together with their carers, were offered an annual review with a 30 minute appointment.

Arrangements to deal with emergencies and major incidents

Potential risks to the service were anticipated and planned for in advance. Emergency medicines were held securely and regularly checked by one of the nursing staff to ensure they were in date and suitable for use. The practice had access to oxygen in the event of an emergency, and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available. Staff were trained in dealing with medical emergencies including basic life support skills.

A disaster recovery and business continuity plan was in place. The plan included the actions to be taken following the loss of the building, loss of computer and electrical equipment and loss of utilities. Key contact numbers were included for staff to refer to.

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. 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.

Patients newly registered with the practice filled in a health and lifestyle questionnaire and were asked to see a member of the clinical staff if issues were raised. They were offered an NHS health check if appropriate.

When patients were first registered with the practice, the nurse practitioner carried out a full health check which included gathering information about the patient's individual lifestyle choices as well as their medical conditions. Referral to secondary care was made as required.

The GPs lead in specialist clinical areas such as diabetes, heart disease and asthma, and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the care of patients' health care needs.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients' care and treatments were based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

GPs attended regular meetings with the Clinical Commissioning Group, so they were aware of developments in the local area.

Long term and chronic conditions were assessed and managed through the appointment recall system. This area of work was led by both GPs and practice nurses although they both had different areas of responsibility for patient care. For example, nurses tended to do practical procedures such as spirometry and GPs took responsibility for discussions about medicines and hypertension control.

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 to support the practice to carry out clinical audits.

The practice showed us that clinical audits had been undertaken in the last year, and the practice was able to demonstrate the changes resulting from the initial audit. For example, Vitamin D and calcium supplementation for patients with osteoporosis and the prescribing of antipsychotic medicines for patients with dementia. The staff we spoke with discussed how they reflected on the outcomes being achieved in the audits that were carried out and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement

Referral rates to secondary care were monitored to ensure this system was improving outcomes for patients. Unplanned admissions to A& E were monitored and follow up appointments were offered to patients within three days to establish the reason for the admission and to see whether interventions from the practice would be more effective.

The practice participated in the Quality and Outcomes Framework (QOF) system. This is a system for the performance management of GPs. It is intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed about average in maintaining a register for patients with a learning disability, a register of patients in need of palliative care and support and having regular multidisciplinary reviews of patients on the palliative care register.

Good

Are services effective?

(for example, treatment is effective)

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

We spoke with a foundation level 2 GP during the visit. They told us they received an extensive induction process prior to joining surgery. The induction process lasted almost two weeks and included an introduction to the IT system and time spent shadowing the GPs. They then started on structured longer appointment times with allocated debrief sessions during the day to discuss their work. The GP said they felt challenged academically but never placed in an unsafe situation. Before they started working at the practice, they were asked to supply certificates of training as well as Disclosure and Barring Service check along with a copy of their medical indemnity cover. There was also an allocated debrief time at the end of every surgery and open door policy with both GPs. Protected learning time was in place each week which encouraged them to identify and address their learning needs.

Locum GPs were rarely used. They had been used twice in the last 12 months to cover annual leave although they could be used in the case of an emergency. The practice manager was responsible for all checks including Disclosure and Barring Service checks and indemnity cover. Locums were provided with a brief induction prior to their surgery which included the IT systems and practice referral pathways.

An appraisal system was in the process of being developed for clinical and non-clinical staff. The purpose of this was to review staff performance and identify staff development needs for the coming year.

Staff spoken with told us senior staff were supportive of their learning and development needs and they felt well supported in their roles. They said they had undertaken the training needed for their roles.

The GP annual appraisals and revalidation was up to date. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. GPs told us they had protected learning time and opportunity to reflect on their practice, review their training needs and identify areas for development.

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other. Regular developmental and governance meetings took place to share information, look at what was working well and identify where any improvements needed to be made.

All clinical staff including nurses and health care assistants received one week flexible study leave each year. The practice paid for the nursing and health care assistant professional development. All staff had protected learning time of two hours when the practice was closed. A structured learning programme was in place for this time.

Working with colleagues and other services

Care provided for patents at the end of their life was managed by one of the GPs. They aimed to have continuity of care with same GP. Carers were always informed of any decisions made, and the out of hour's provider was notified of patients' palliative status. District nurses were kept informed of relevant information and authorised to issue palliative medicines. The local hospice provided palliative care nurses and support for opinions and advice. The Gold Standards Framework was in place, and meetings were held every three months to share information and ensure all relevant health care professionals were kept informed of patient care issues. The meetings were attended by GPs, district nurse, palliative nurse. A record of these meeting was kept.

The GPs were involved with mental health services and attended Community Psychiatric Nurse meetings as needed to support patients with mental health problems. There was involvement with multi-disciplinary team meetings to discuss unplanned admission to A&E. Clinical staff also attended monthly Clinical Commissioning Group learning forums.

Work was carried out with local drug and alcohol service with a drug and alcohol support worker providing a service from the practice once a week to support patients in this area of their care needs.

Information sharing

The practice used an electronic system to communicate and share information with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals through

Good

Are services effective?

(for example, treatment is effective)

the Choose and Book system. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Reception staff were fully trained in the use of the IT systems. Staff knew to keep information about patients confidential and only share this on a need to know basis.

Regular meetings involving the practice manager and non-clinical staff took place to ensure they were fully informed about the systems in place for the running of the service. GPs regularly met with the clinical staff. Information about risks, significant events, and patient care issues were discussed to ensure all staff had all the information they need to deliver effective care and treatment to patients. Other health care professionals attended the meetings as needed.

The practice website provided patients with information about the services offered. It also included links to other websites relating to health care organisations.

Staff shared information with the out of hour's provider, so they were fully informed about patients' needs during the out of hour's period. This enabled continuity of care for patients with a terminal illness, complex mental health issues or those who have in place any advance care instructions.

Consent to care and treatment

Consent to treatment was obtained by the use of a particular IT system. This generated a letter with patients' permission for treatments and for a referral to secondary care.

The practice ran a family planning clinic and GPs demonstrated a clear understanding of the use of the Gillick competency. The Gillick competencies help clinicians to identify young people (aged under 16) who have the legal capacity to consent to medical examination and treatment. An example was discussed which demonstrated the use of the Gillick competencies which assessed any risks to a patient and routinely asked safeguarding questions to ensure their welfare.

The relatives of patients with a learning disability were invited to meet with their GP to discuss the person's best interests. This was in line with principles of the Mental Capacity Act to determine if the patient had the capacity to make a decision for themselves or not.

There has been no formal training about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) but GPs were aware of the principles of MCA through professional practice. DoLS were discussed during clinical meetings, so all staff were aware of the requirements of DoLS and the impact this has on patient care.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice nurse and health care assistant offered appointments from 8 am to people who were at work and staff actively promoted NHS health checks. A full range of family planning services were available on site including implants and coils. Baby clinics were timed to run alongside health visitor clinics within the building. This provided maximum convenience for families and maximised on immunisation rates.

Staff were proactive in offering flu, pneumonia and shingles vaccinations to those eligible or in at risk group such as those patients over 65 years of age.

The practice offered smoking cessation advice and treatment and patients had access to the local service clinics within the building.

The health care assistant carried out NHS well-being checks during which time they actively promoted good health care. Health promotions leaflets and posters were displayed in the patient waiting area. Opportunistic advice was provided during consultations to patients with obesity or alcohol problems when deemed necessary.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There is a door between the administration office and reception area which meant conversations could not be overheard. Reception staff interacted with patients quietly and respectfully when speaking with them on the phone or directly when they came into the surgery. Reception staff do not telephone GPs during patient consultations unless in an emergency to respect patients' confidentiality.

Feedback on the patient comment cards we received was very positive about the way they were treated by staff. Patients commented that staff were friendly and caring with a pleasant attitude. They noted that they felt listened to during consultations and that GPs understood their care needs. Patients noted they were always treated with respect.

Patients spoken with said they were always treated with dignity and respect. They described the staff as very helpful and the GPs as very good. They said the staff went out of their way to make them feel at ease.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. National GP survey results published in July 2014 the following:

83% of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern. The national average is 85%.

Care planning and involvement in decisions about care and treatment

Patients whose long term conditions left them at increased risk of hospital admission were covered by the Unplanned Admission Enhanced Service. Their care plans were reviewed regularly to ensure they accurately reflected their current health care needs. An annual review was offered to patients with complex mental health needs with a care plan drawn up as appropriate. Through a local enhanced service, the practice cared for the majority of patients in a local nursing home. These were predominantly patients with a history of dementia. Staff offered a weekly review visit of any patients needing care and annually reviewed care plans and planning for end of life care.

We looked at the results of the 2014 GP patient survey. The National GP survey results published in July 2014 indicated that 76% of respondents to the survey stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care. The national average is 82%.

Patients' carers were involved in the patients' care planning and decision making to ensure they received the right treatments and level of care. Patients' care needs were regularly reviewed and more often as needed with carer input taken into consideration when making decisions. Although there was no formal register of carers, this information was recorded on a patient's notes so they could be directed to carer support agencies. GPs were keen to ensure that carers and advocates had a single point of contact to ensure continuity of care.

Patients spoken with said the nurse or GP explained their treatments and the risks involved, and they felt listen to when they discussed their treatment options. Patients said that referrals to secondary care were completed in a timely manner, and they were given the opportunity to discuss their choices.

The CQC intelligent monitoring for Dec 2014 showed concerns with regard to dementia figures and low Mental Health Care Plan reviews. A review of this area of care was completed. 100% of patient care needs were reviewed in 2014 / 2015, with a recall appointment set for the following year.

Patient/carer support to cope emotionally with care and treatment

Patients and those close to them received the support they needed to cope emotionally with their care and treatment. The telephone triage service allowed for a quick response to patients who felt their mental health was deteriorating, or they were at crisis point. Longer appointments were offered when needed. Annual reviews were offered for patients with complex mental health needs with care plans put in place as appropriate. Clinical staff engaged with a local dementia diagnosis and management enhanced service which meant more patients could be diagnoses and managed at the practice by familiar GPs rather than being referred secondary care. An annual review and physical health checks were offered to patients with dementia.

Staff worked with local services Bury Drug and Alcohol Team to support patients with addiction. A drug counsellor

Good

Are services caring?

attended the practice to see patients once a week, and a GP lead from a neighbouring practice provided specialist support for these patients. An alcohol rehabilitation service was available for patients in the local area.

For bereaved patients, GPs called relatives to offer their condolences and then offered an appointment for support. Bereavement counselling services were available for family members, and carers and staff would direct them to carer support agencies as required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice routinely assessed support systems in place for underage patients who were pregnant, as well as safeguarding concerns. Patients could now book appointments directly with a midwife rather than see a GP as the first port of call.

Responding to feedback form CQC intelligent monitoring from Dec 2014 showing low dementia assessment figures and low mental health care plan reviews. This situation was reviewed, and GPs have now instigated a review of registers, inviting patients to make an appointment to reviews their care needs with a recall appointment set for the following year. This had resulted in an outcome of 100% for 2014/15.

A key concern raised by patients via patient satisfaction surveys and past Friends and Family surveys related to the availability of appointments. As a result of this the entire appointment system has been redesigned. A new system was introduced in April 2014, and although a formal evaluation of the success of this system had not yet been conducted, informal feedback was very positive. For example, the practice readily offered a same day appointment for patients who may be deemed in vulnerable circumstances via the new telephone triage system.

We were given an example of how the practice responded to and met patients' needs. This involved a patient with unplanned admissions into A&E. There was multi-disciplinary and secondary care involvement to try and support this patient who had not made any contact with regular GP services. Reserved appointments were in place for A&E and walk-in centre doctors to refer non urgent cases and those deemed inappropriate back to the practice for treatments.

Tackling inequity and promoting equality

The services provided took account of the patients' needs including those in vulnerable circumstances. Staff recorded clearly in patient notes where they had been notified of circumstances that may make them vulnerable. For example patients who misused substances, those who experienced domestic violence or had mental health problems. Staff ensured this was done in a way which protected patients' confidentiality. Clinical staff were involved in inter-agency meetings such as vulnerable adult meetings. Reception staff were alerted by red flags on the IT system to patients who failed to collect their prescription and clinical staff were notified. Close links were maintained with Bury Drug and Alcohol Team to support patients with addiction and who may not readily come forward for health care. The practice offered a same day appointment service via a new telephone triage system for patients who were hard to reach.

We were informed that many of the patients did not speak English. An interpreter service was used to support these patients and double appointments were booked for this purpose. For patients with a hearing impairment, communication was via writing with a sign interpreter available if necessary. One of the GPs spoke a number of languages which also supported patients. A hearing loop was available for patients who were hard of hearing and a disabled toilet was available along with baby changing facilities. Disabled parking was available near to the practice.

Access to the service

Patients could access care and treatment in a timely way for diagnosis and for treatment or on-going management of chronic conditions. The practice was part of the "Easy GP" scheme run by Bury GP Federation (this is part of the Prime Minister's Challenge Fund). This gave all patients access to routine pre bookable and same-day GP appointments at four sites across the Bury area. Patients had access to appointments from 8 am to 8 pm Monday to Friday and from 8 am to 6 pm at the weekend. We were informed this was proving popular with patients who went out to work. Telephone consultations and home visits were available and information about how to book these appointments was on the practice website. Information about who patients should contact out of hours was also on the practice website.

A robust recall system was in place for annual reviews and other monitoring for patients with chronic diseases and long term conditions. immunisation clinics fitted around school times. The practice was conveniently located for public transport, and there was ample secure parking adjacent to the building.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The appointment system was continually monitored and had recently been reviewed and changed in response to patient feedback. Telephone triage took place and same day, and online and routine appointments were available within one week.

Patients spoken with gave a mixed response when asked how easy it was to get an appointment. Some patients reported they were able to book an appointment quite easily while others said that more recently, they found it difficult to book an appointment. This was also reflected in some of the CQC comment cards that patients had completed prior to the inspection. They indicated that for the most part patients were happy with the appointment system, although a couple of patients commented they found it difficult to make an appointment.

The practice was part of the 'zero tolerance scheme' with a neighbouring practice and would take registration from patients removed from previous practices for violent or aggressive behaviours. This supported these patients to access the service when in need of medical care.

A practice leaflet was available in the patient waiting area which included details of the services provided, opening times, staff details and information about prescriptions.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available in the patient waiting area and on the practice website. One of the GPs was responsible for managing complaints, with the practice manager being the designated contact person. We looked at the record of complaints and found documentation to record the details of the concerns raised and the action taken. We were informed about a significant event analysis where the staff had proactively referred an example of poor care from secondary care service into the Clinical Commissioning Group for investigation.

Staff were clear on the action they would take if they received a complaint. They knew to give patients a copy of the complaint procedure, so they were aware of timescales for the investigation of their complaint. A whistleblowing policy was in place. Instances of whistleblowing have not occurred in the practice. However, GPs were clear on the action they would take if a member of staff raised a concern under these procedures.

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 vision and strategy to deliver high-quality care and promote good outcomes for patients. The practice vision was to provide the highest quality of care to all patients, especially in the context of an evolving and changing NHS. There was a clear leadership structure with named members of staff in lead roles that helped to lead and mentor the practice staff.

Clear objectives had been set for the next 12 months. Plans were being made to set up a robust electronic document management system and IT system for contemporaneous medial record updates when out of practice, for example when using a tablet. Arrangements were being made to enhance the training for the health care assistant to increase their remit and reinstating the annual appraisals for clinical and non-clinical staff. Work was also being carried out to reinstate the Patient Participation Group (PPG). A PPG is a group of people who work with the practice staff to improve services, promote health and improve the quality of care.

The staff we spoke with said they were very happy working at the practice. The trainee GP (foundation year 2) said they felt very well supported by both GPs. They said there was an open door policy for assistance and they attended practice meetings to ensure they were fully informed about the running of the practice. They highly recommended this placement. They said they would feel confident to us e the whistleblowing procedure if necessary, but had no reason to do this. We spoke with a member of the administration staff. They said they were very happy working at the practice. They saw the practice manager every day who they described as approachable. They attended daily meetings and felt able to escalate any concerns with ease. They identified the practice mission statement was to provide the highest level of care to all patients. They felt that senior staff kept them informed of all major changes and future developments.

Governance arrangements

There was a business risk register which was actively updated. The practice manager was responsible for managing and monitoring this information to ensure it was up to date. Business meetings took place every three weeks to ensure good communication.

The practice manager was responsible for human resources such as managing staff performance. There were designated clinical roles amongst GPs. One GP was responsible for managing safeguarding, adults and children another GP was responsible for overseeing patients' long term conditions.

The practice had a number of policies and procedures in place to govern activity, and these were available to staff electronically or in a paper format.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The GPs spoken with told us that the QOF data was regularly discussed, and action plans were produced to maintain or improve outcomes.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment provided. A discussion with the GPs showed improvements had been made to the operation of the service and to patient care as a result of the audits completed.

The practice had systems in place for identifying, recording and managing risks. We looked at a number of significant incident reports and actions taken as a result of these reports. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

Leadership, openness and transparency

Staff spoken with said management was visible and approachable. They said they fostered positive working relationships between all the staff which supported good team working.

Staff told us that there was an open culture within the practice, and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager or one of the GPs. Staff told us they felt the practice was well managed. Regular governance meetings took place to share information, look at what was working well and identify where improvements needed to be made.

GPs demonstrated how they created a culture which centred on the needs and experience of patients who used the service. They understood the challenges to provide good quality care and could identify the actions needed to address these challenges.

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

All staff were fully consulted at times of change, for example when the appointment system was being redeveloped. Once a week the practice manager meets with senior administrative staff to discuss any issues raised from team meetings. Monthly meetings provided nursing staff with an opportunity to discuss clinical issues and anything relating to their role.

Complaints were monitored for trends and patterns and staff acted on this information to improve or change services. We looked at the complaints log including ones received by telephone. We saw an example of detailed written notes made by the complainant and the letter written back with positive outcomes. There was evidence of subsequent learning from complaints and changes made to practice to improve outcomes for patients.

We looked at the information gathered from the Friends and Family test carried out in April 2015. This patient survey asked patients how likely they were to recommend the surgery and services to friends and family. Eight comment cards were completed. They all indicated they were 'extremely likely' to recommend the practice to friends and family. Additional comments were very positive about the service provided and the staff. Patients described the service as excellent and the staff as friendly, professionals and accommodating.

Management lead through learning and improvement

Management and governance of the practice supported learning and improvement. Staff reported that protected learning time was available so they could attend training for their development. They said they enjoyed their work and felt well supported in their roles. Regular meetings took place, so staff had an opportunity to share information and identify where improvements needed to be made in the service provision. Work was being carried out to set up a system of staff appraisal for administrative staff so they had the opportunity to develop in their role.

There were systems in place to record incidents, accidents, and patient satisfaction surveys, complaint monitoring and significant events and to identify risks to patient and staff safety. The Quality and Outcome Framework targets were reviewed, for example, admission rates to A & E. The results were discussed at practice meetings and if necessary, changes were made to the practice's procedures and staff training.