Ramsbottom Medical Practice

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ramsbottom Medical Practice on 21st May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. It required some improvements in safety. The practice was good for providing services for all the population groups.

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

- The practice had undergone a period of considerable change over the previous eighteen months. During this period when there had been alterations to the structure and to the staff and leaders, the practice had continued to provide an effective service to its patients.
- 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 with the exception of risks relating to recruitment checks such as the retention of required documentation for all members of staff.
- When things went wrong, information about the event and learning was not always effectively shared so that all staff knew how to minimise re-occurrence in the future.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Not all staff received support and training appropriate to their roles. Prior to the inspection, training needs had been identified and planned but training that had been provided and undertaken was not consistently recorded.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand.
- Some patients said they found it difficult to make an appointment with a named GP in a timely manner. However they said there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. We found concerns that the reception and waiting area were too small and patient conversations could be overheard.
- There was a newly embedded leadership structure whereby staff felt supported and knew who to approach regarding different issues.
- Policies, procedures and protocols were available for staff to refer to in various different areas of the practice. Some policies needed review so that they reflected current practice and all policies needed to be in one easily accessible place for staff to quickly refer to without having to leave their work station.
- The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly, the provider must:

- Ensure systems to manage medicines are effective.
- Ensure that recruitment procedures are established and operated effectively and the information specified in Schedule 3 is available in relation to each person employed by the practice.

In addition the provider should :

- Establish and effectively operate systems that assess, monitor and improve the quality and safety of the services provided..
- Operate a service which is transparent, collaborative and open about performance and that events of significance and any learning therefrom is shared with all relevant staff.
- Provide policies and procedures which are practice specific, are reviewed and kept up to date and are easily accessible at all times by all members of staff.
- Implement a system to identify, record and effectively plan all staff training and provide support, training and appraisal that is consistent for all members of staff..

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. There was a system to record, review and learn from concerns, safety incidents and near misses and staff fulfilled their responsibilities in these areas. When things went wrong, reviews and investigations were not always shared widely enough for all staff to benefit. There was some inconsistency of staff awareness of events and learning therefrom, relevant to their role. Some action was required to ensure that all necessary recruitment documents were received and retained, that all checks on medicines were effective and that systems were in place to record and plan training for all staff. Staff levels and skill mix were effectively reviewed to keep people safe at all times. Staff recognised and responded appropriately to signs of deteriorating health and medical emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes had been reviewed by the practice and were improving. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff training had recently been reviewed and training needs had been identified and planned. Appraisals had been completed for most clinical staff and training needs had been identified and planned. Pre-appraisals had been completed for most administration staff with dates for appraisal to be arranged. Staff were consistent in supporting people to live healthier lives and were pro-active in health promotion.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were satisfied with the care provided. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff responded compassionately when people needed help and treated patients with kindness and respect. We found concerns relating to privacy in the waiting room

Summary of findings

where information and conversations between staff and patients could be overheard. This was something that the practice were aware of and were in discussion with the landlords about to arrange further structural changes.

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. Some patients said they found it less easy to make an appointment with a named GP but most patients said that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was evidenced and a report of complaints was shared with the CCG.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had suffered a significant period of change and insecurity and there had been a number of staff changes. New leadership and effective clinical teams had created a positive structure where staff were aware of their roles and responsibilities. The vision of the leaders to provide caring and effective treatment for patients was shared by all staff we spoke to. Some policies and procedures needed to be updated and all policies needed to be easily accessible to staff. There were good systems to monitor outcomes and effectiveness. Some systems to monitor governance needed to be more effective. The practice proactively sought feedback from staff and patients, which it acted on there was an active patient participation group who helped drive improvement. Newly employed staff had received inductions and regular performance reviews and all staff attended some staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. One of the GP partners took the lead in dementia and palliative care. The practice were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice were involved in the £5 per head scheme (funding provided by the Government). They had allocated some of this funding to older people and increased nursing hours so that care plans and health checks could be put in place for all those who required them. They made a weekly visit to patients in a nursing home which had a positive impact on the patients and reduced the frequency of visit requests for acute exacerbations of illness.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff and the advanced nurse practitioner (ANP) had lead roles in chronic disease management with input from GPs as and when required. Registers were held to identify patients with long term conditions and patients were reviewed on an annual basis or more frequently if required. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice held regular chronic disease management clinics and practice nurses visited housebound patients to administer flu injections and carry out other health checks where necessary. Patients were encouraged and assisted to self-manage their conditions and were signposted to extra support organisations.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were appropriate for all standard childhood immunisations. Staff told us that children and young people were treated in an age-appropriate way and were

Summary of findings

recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those in nursing homes, housebound patients living alone and patients with a learning disability. These patients received regular follow up and annual health checks. Other health and social care professionals were liaised with when required. We saw evidence that patients had been given information about how to access the practice and other outside organisations in times of crisis. Staff knew how to recognise signs of abuse in vulnerable adults and children and we were given examples of where appropriate agencies had been contacted when required.

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). One of the GP partners took the lead for dementia and palliative care. They had recently undertaken additional training to support them in this role and help the practice to provide positive outcomes for patients in this category. A substance misuse clinic took place on a weekly basis to support patients with substance misuse problems registered at the practice. Patients experiencing poor mental health were given information about how to access various support groups and voluntary organisations such as MIND and SANE. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff were advised on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke to eleven patients including three members of the patient participation group (PPG). We also reviewed the GP patient survey data, feedback from seven CQC comments cards and discussed the Friends and Family responses with the practice.

We asked patients if they felt impacted by the structural and staff changes over the previous eighteen months and if they felt improvements had been made. The patients we spoke to said that they had not been affected by any of the changes and that the service had always been satisfactory.

None of the patients we spoke to reported any issues with access to the service. On the morning of the inspection four of the patients spoken with had received their appointment that day. The patients we spoke to were happy with the service they received and said they felt included in their consultations and informed about their treatment. We spoke to a patient with disabilities who reported good access and said that they had a care plan. We spoke to a carer who felt involved and included in the care and treatment of the person they cared for and said that confidentiality was maintained and consent was appropriately asked for. We spoke to a mother and baby who reported that breast feeding was promoted and encouraged with areas of privacy available.

PPG members were positive about the efforts by the practice to improve services based on requests and feedback from patient representation. The CQC comments cards provided positive feedback about the services and treatment provided. Only two comments highlighted issue with accessing the service.

Areas for improvement

Action the service MUST take to improve

- Ensure systems to manage medicines are effective.
- Ensure that recruitment procedures are established and operated effectively and the information specified in Schedule 3 is available in relation to each person employed by the practice.

Action the service SHOULD take to improve

- Establish and effectively operate systems that assess, monitor and improve the quality and safety of the services provided..
- Operate a service which is transparent, collaborative and open about performance and that events of significance and any learning therefrom is shared with all relevant staff.
- Provide policies and procedures which are practice specific, are reviewed and kept up to date and are easily accessible at all times by all members of staff.
- Implement a system to identify, record and effectively plan all staff training and provide support, training and appraisal that is consistent for all members of staff..

Ramsbottom Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP adviser, practice manager adviser and an expert by experience who is someone that has been trained by CQC and has used health and social care services.

Background to Ramsbottom Medical Practice

Ramsbottom Group Practice is a family GP practice based in Ramsbottom Health Centre. During the last eighteen months the practice has undergone major structural improvements and considerable changes to partners, nursing and reception staff. This period of change is over and the practice now have four partners of mixed gender, one salaried GP, an advanced nurse practitioner (ANP) and a full complement of nursing and administration staff. The practice did not train junior staff but they offered temporary posts to asylum seeker GPs who could gain experience and improve their English prior to sitting their Professional and Linguistic Assessments Board Test (PLAB). The PLAB test is for doctors who have qualified overseas and wish to practise medicine in the UK under limited registration. The test assesses their ability, as a doctor, to work safely as a senior house officer (SHO) in a UK NHS hospital.

The practice provide a wide range of NHS services under a Primary Medical Services contract with a list size which has increased over a number of years from 2,500 to 8,500 patients. These include family and maternity services, a full contraceptive service, clinics to manage long term conditions, access to a weekly drug addiction service and some minor surgery procedures.

Patients can arrange appointments or order prescriptions in person, by phone or via the web, and are encouraged to provide feedback on the services offered. Appointments can be booked in advance or on the same day and telephone consultations with a GP or the ANP are available if requested.

The surgery has been recently modernised and complies with the Disability Discrimination Act providing easy access via ramps outside the property and access to consulting rooms on the ground floors when required.

The building is open between the hours of 8am and 6pm from Monday to Friday and is closed at weekends. The phone lines for the practice close between 12.30pm and 2pm each day and an answer message provides emergency contact numbers. There are a minimum of six surgery sessions each day and surgery hours are 9am till 12.30pm and 3pm until 5.30pm daily. When the practice is closed an out of hours service is available and patients can access the Walk In Centre at evenings and weekends.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and pre-inspection information received from the practice manager. We asked other organisations to share what they knew. We carried out an announced visit on 21st May 2015. During our visit we spoke with three GP partners, the practice director/ manager, the advanced nurse practitioner and one of the practice nurses. We also spoke to four reception staff, eight patients and three members of the patient participation group (PPG) who were also patients. We reviewed feedback on seven CQC comments cards.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice reported, recorded, monitored and investigated significant events. They kept paper records of all significant events and we saw these dating back to the year 2011. The practice also used a range of other information to identify risks and improve patient safety. These included national patient safety alerts, feedback from the medicines management team and comments and complaints received from patients. There was an accident book where staff recorded any accidents or health and safety incidents that happened at the practice. Clinical and non-clinical staff knew how to record and report any information of significance and were aware of their responsibilities to raise concerns. Most concerns were reported to the practice manager who escalated and directed them to the most appropriate person for investigation. The practice held meetings where significant events were discussed but attendance was mainly limited to the GP partners who made decisions about action to be taken.

Learning and improvement from safety incidents

We looked at the significant events dating back to 2011. We were also sent a summary of events that had happened in the year 2014 and 2015. The reports we looked at recorded details about the event, what had gone wrong, what had been learned and what had been changed. There was evidence that the practice had learned from the events we reviewed, that practice had been changed and that staff learning had been disseminated to relevant staff. A member of reception staff demonstrated a new system in place to combat missing information around warfarin prescriptions. Different staff we spoke to demonstrated different levels of awareness around some of the most recent events that had happened. This showed us that there was opportunity for the practice to hold regular meetings with representation from all staff disciplines so that learning could be shared more widely.

Reliable safety systems and processes including safeguarding

Risks to vulnerable children, young people and adults were managed and reviewed appropriately. We spoke to staff both clinical and non-clinical who demonstrated awareness of safeguarding and were able to describe situations where they would consider safeguarding issues that needed to be reported. Examples included detrimental behaviour towards children by an adult or a patient who appeared suddenly dishevelled or unkempt. Nursing staff we spoke to gave examples where they had reported concerns to the appropriate safeguarding authorities. Nurses told us they had undertaken safeguarding training to the appropriate level and we saw that updates had been arranged for later in the year.

We spoke to the medical staff who also provided examples where safeguarding concerns had been discussed and actioned. One of the GP partners was the safeguarding lead for the practice. We were told that they had been trained to the appropriate level 3 and that refresher training was overdue. We saw however that Level 3 training had been arranged for later in the year. Minutes from the Clinical Commissioning Group (CCG) wide safeguarding meetings were received and disseminated and staff signed them to say they had been seen.

Non clinical staff we spoke to demonstrated different levels of awareness and understanding and some were not certain when they had last received training in the subject. We saw that training had been delivered by the CCG some years previously and were told that this had been updated in-house, using the slides provided by the CCG. We saw that further level 1 training for all staff had been arranged for later in the year. There were policies and procedures about safeguarding available for staff to refer to which had been written by Bury Council. However there was no practice specific policy on this subject.

There was a yellow alert system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments such as children subject to child protection plans and/or missed appointments. There was a chaperone policy, which was visible in the waiting room and in consulting rooms. Patients knew they could request a chaperone if they wished. (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). One of the non clinical staff we spoke with told us they had provided chaperone services .The practice told us that they were keen to ensure that only nursing or medical staff acted as

chaperones and those we spoke with were aware of their responsibilities including where to stand to be able to observe the examination. Chaperone training was being provided to all staff later in the year.

Medicines management

Management and prescribing of high risk medicines such as antidepressants and tranquilizers had, under the previous leadership, been identified as a potential risk by the medicines management team. The practice had now introduced a system to minimise this risk and changed the way those medicines were prescribed. All staff were aware of the new process and the practice found that although it had increased their workload, those medicines were now prescribed in a safer and more effective way.

The practice undertook clinical audits to ensure they were adhering to guidelines for prescribing. We reviewed three audits which had looked at how the practice prescribed medicines used for contraception, anti-sickness, and anxiety and depression. Where issues had been identified these had been addressed and the practice ensured they were prescribing appropriately. We saw that relevant notes were made on the patient's record where required. GPs spoken with were aware of these audits.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines stored in fridges were in date and kept at the required temperatures. The contents were audited monthly and stocks were kept low to minimise the chance of any reaching the end of their shelf life. The policy described the action to take in the event of any potential failure but there was no one with direct responsibility for ensuring the policy was adhered to. Medicines stored in fridges were checked and seen to be in date.

The nurses administered vaccines using directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines. Blank prescriptions and prescriptions used in the electronic system were handled in accordance with national guidance, tracked through the practice and kept securely at all times.

The GPs did not keep medicines in their bags. Medicines that may be needed during a home visit were stored in a visit box ready to be taken out by the visiting GP. There was a system to check that all the necessary medicines were always in the container and that they were in date. We were advised that this was done monthly and that the person responsible would be advised when any medicines had been removed or used by a GP. We reviewed the contents and found that one of the medicines had recently expired and had not been removed or replaced. A medicine we would have expected to be carried was not in the container (salbutamol). This was included in the list of medicines for the emergency bag but had been removed by a clinician and had not been replaced. There was only one container of medicines meaning another was not available if that one was taken on a visit. The practice had risk assessed this and there had been no reported issues. We also checked the emergency medicines. We found that the contents included two vials which had recently expired and had not been removed. However was saw there were two vials of the same medicine which were in date.

Cleanliness and infection control

The practice had previously declared non-compliance in this area following their registration in 2013. Building work which was being carried out to improve the premises and the practice was unable to move into different premises during that time. They subsequently ceased all treatment that might have been impacted by a lack of infection control such as minor surgery until the work was completed.

Following completion of the work an infection control audit was carried out. Requirement actions included monitoring the work carried out by the cleaners to ensure it was completed effectively, weekly and monthly checklists that specific areas had been cleaned, sharps bins to be bracketed to walls, fabric chairs to be replaced, the introduction of an infection control lead and an infection control policy to be implemented and kept up to date.

The advanced nurse practitioner (ANP) had been given the role of infection control lead prior to our visit. They had not received specific additional training to carry out this role but advised us that infection control was part of their continuing professional development. We discussed the actions identified in the last audit. We were shown that most of the requirements had recently been actioned. For example, prior to our visit checklists had been put up to

ensure specific areas were cleaned, sharps bins had been fastened to the walls and fabric chairs had been replaced. A re-audit had taken place on the Monday prior to our inspection and did not identify any major issues.

All areas of the practice we looked at were clean and hygienic. Worktops in treatment and consulting rooms were tidy and uncluttered. Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. We saw that treatment beds were wipeable and curtains were disposable. Disposable equipment was used for minor surgery and other treatment related procedures. Nurses told us they were responsible for cleaning their own equipment such as auroscopes and spirometers (equipment used for looking in people's ears and checking people's breathing) but this was not documented.

The infection control lead had carried out hand hygiene training with all members of staff and assessed their competence. All staff had had their Hepatitis B status checked and if required had received a booster. We saw that two staff had declined the vaccine and had signed disclaimers. Non clinical staff we spoke to expressed knowledge of what to do in the event of a spillage of urine, blood or vomit and assured us that spillage kits were available. We saw advice for patients and staff about infectious diseases such as Ebola. We saw that infection control matters were raised and documented in meeting minutes when required. Personal protective equipment was available such as disposable aprons and gloves and notices about hand hygiene was displayed. Hand washing and alcohol gels were available in treatment rooms.

The water tank had been removed from the building and the landlords for the building were responsible for testing for legionella. A report was available in the Building Operating Manual cupboard and we saw documents dated 30th October 2014 in relation to this.

Equipment

Staff we spoke to told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Maintenance of equipment was the responsibility of the practice and mostly carried out by the landlords of the property. We saw evidence that portable appliance testing, calibration of scales, blood pressure equipment and fridges had been completed in September 2014. Equipment used for minor surgery was single use and was safely and securely disposed of after use in line with practice policy and national guidelines.

There were also arrangements in place to check the working order of the defibrillator, pulse oximeter and oxygen. We saw that these were checked and in good working order. The defibrillator had been checked on the morning of our inspection.

Staffing and recruitment

Records we looked at during the inspection did not all contain evidence that appropriate recruitment checks had been carried out and retained prior to employment such as written references, proof of identification, explanation of gaps in employment 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 which included the requirement for satisfactory references and documentation confirming the individual's right to work in the United Kingdom. The practice manager told us that most staff were employed following personal recommendations and references tended to be verbal. The policy did not mention the requirement to carry out DBS checks although we saw those available for clinical staff. We were advised that non clinical staff were due to receive chaperone training. We highlighted that staff who carried out chaperone duties required a DBS check and were assured that this would be done going forward.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts and we saw documented evidence that new staff received an induction. Staff felt there was enough of them to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the environment,

medicines management, staffing, dealing with emergencies and equipment. Some of the checks, such as those for medicines management and recruitment required review to ensure they were effective. The practice also had a health and safety policy which stated that the partners held overall responsibility in this area. The landlords of the premises identified if there were any health and safety issues. For example they suggested that some chairs required replacing and this was done. Risk assessments were carried out when required and we saw an example of one undertaken for a pregnant member of staff.

There was a system to manage clinical risks, such as patient searches to ensure treatments were up to date and appointments were not missed. We saw how missed appointments were monitored and some patients (if felt at risk) were telephoned to check the reason for their non-attendance. Mental health registers flagged patients in crisis and any risks to staff, if identified, (such as information not to visit a patient alone) would be recorded. There was also a system in place to track referral letters made by the GPs to secondary care.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Staff told us about two medical emergencies and explained the action taken. The practice had discussed the events and shared learning from it. They had recently reviewed the way they managed their emergency medicines and had reduced the number of visit boxes.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. However we found two vials which were not in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to such as heating and electrical companies.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records did not evidence that staff were up to date with fire training. However they knew what to do in the event of fire and how to protect patients. Risks associated with service and staffing changes (both planned and unplanned) were included in the health and safety protocol.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff we spoke to explained the rationale behind their approach to treatment which followed current best practice guidance. All clinicians accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw information which evidenced that new guidelines and any implications on the practice or its patients were discussed. Actions required were agreed and changes in practice made if required. We saw that any actions were designed to make sure that each patient received the support required to achieve the best health outcome for them. We saw that GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Patients were not discriminated against and all assessments were made in line with each patient's needs. New patients were assessed and diagnosed and responsibility of care given to the most appropriate clinician. GPs had lead roles in various long term conditions such as diabetes, asthma and chronic obstructive pulmonary disorder (COPD). They supported the Assistant Nurse Practitioner (ANP) who managed care of most of the long term condition patients. One of the GP partners took the lead for dementia and palliative care. They had recently undertaken additional training to support them in this role and help the practice to provide positive outcomes for patients in this category.

Quality meetings between the practice manager and the GPs took place to discuss the Quality and Outcomes Framework (QOF) and any action they could take to provide better services or increase performance. We saw that the practice had identified areas that required attention and had focused on those areas to increase the quality and service provided. Data we reviewed evidenced improvement in those areas such as dementia, flu vaccine uptake and total QOF points which had risen from 81% overall maximum in the year 2013/14 to 96.4% in the current year. Nurses had divided QOF into target areas so that figures were worked on throughout the year.

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, managing recalls and keeping patient registers up to date. Registers included patients with learning disabilities, mental health, those who were housebound, children at risk and those with various long term conditions. Information and advice was collected and collated and used to inform patient care and clinical audit. We saw examples of audits around medicines which had been undertaken to improve standards of care and manage any contra indications which may affect patients. We saw that audits had been repeated on two occasions showing positive improvements each time. Discussions with nursing staff identified that they were not included in clinical audit. They reported that nursing audits would be a useful exercise to monitor the effectiveness of the services they provided.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Patients with diabetes had an annual medicine review, and the practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and cervical screening.

There was a protocol for repeat prescribing which was in line with national guidance. Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and held three monthly meetings with palliative care staff to discuss the care and support needs of patients and their families. Information about end of life decisions was shared with appropriate agencies such as ambulance services and that information was updated on a two weekly basis. Feedback from multi disciplinary team meetings about patients nearing the end of their lives was not routinely shared with other members of staff, such as nursing staff, because the GPs provided sole care for those patients.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staff included medical, nursing and health care, managerial and administrative staff. The practice also employed temporary administration staff who were able to undertake QOF checks, summarise patient records and keep information up to date. In addition the ANP was able to prescribe medicines. This role enabled good outcomes for patients who could see the nurse practitioner, rather than wait for an appointment with a GP, if they had acute exacerbation of their long term condition.

We were told that all staff were up to date with mandatory training such as safeguarding and CPR but there was no effective system in place to monitor and record training which was required, undertaken or provided. Staff we spoke to provided different accounts about mandatory training received or due to be undertaken. GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Nurses were responsible for their own continuing professional development. Since the new nursing team and lead nurse role had been implemented, an effective check of compulsory nursing updates was in place. These included cytology, CPR, safeguarding in children and adults, anaphylaxis and infection control. Mandatory training such as fire and health and safety updates were not recorded. One of the nurses who was trained and took the lead in diabetes was now undertaking a module in COPD. Others were being trained to support diabetes patients and the ANP continued with prescribing updates to keep their knowledge current. The ANP had not undertaken any management training to support her in the lead role.

Staff received regular appraisals although these were not up to date for all staff at the time of inspection. However all staff had completed a pre-appraisal form and dates were being arranged for their appraisal. If they had identified training needs in their pre-appraisal then these were being addressed. The ANP carried out appraisals for all the nursing and health care staff and was appraised herself by one of the GP partners. The practice manager carried out appraisals for all administration staff and was appraised herself by the lead GP.

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There was a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held regular team meetings to discuss the needs of complex patients, for example those with complex long term conditions, end of life care needs or children on the at risk register. These meetings involved mainly the GPs at the practice and nurses were invited only when necessary. Recently the format for meetings was changes with a nurse represented at the beginning of the meeting to discuss any patients with complex needs.

Consultation with other health and social care professionals such as district nurses, health visitors, social care services, safeguarding teams or mental health consultant professionals happened when necessary.

Some staff we spoke with reported that communication and information sharing could be improved both within and outside the practice. Further discussion with the GPs and nurses informed us that this was something that was being addressed and one of the GPs was taking a lead role in this area.

Information sharing

The practice used several electronic systems to communicate 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. Choose and Book was also in place for routine

referrals and staff found it useful. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patients referred to A&E were provided with a summary from the electronic system and staff told us that the GP often also wrote an additional letter to ensure that all information was available.

There were systems in place to provide staff with the information they needed. All staff were trained on the electronic patient record used to co-ordinate, document and manage patients' care. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. A new member of staff had been employed to undertake scanning so that it was kept up to date.

Staff internal information systems included access to shared computer drives although this was not something that was proactively used. Policies and procedures were not available on this shared drive.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. We saw information in the practice manager's office about what to do if a patient had a deprivation of liberty safeguard (DoLS) in place. Most of the clinical staff and nursing staff we spoke with understood the key parts of the legislation and good explanations were given of how these were implemented in their practice. Training in mental capacity had recently been completed by the lead GP and courses for other staff were available in November 2015. A member of staff reported that information on this subject would be beneficial currently whilst their role included care planning in nursing homes where a person's mental capacity was not always immediately evident.

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

Different staff we spoke to understood the need for consent and all clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a young person under 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions such as minor surgical procedures or travel vaccinations. A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Nurses explained where they would use implied and informed consent, for example when giving flu vaccines or child immunisations. They also told us different treatment options were explained.

Health promotion and prevention

Patients aged 40 to 75 were offered health checks and we saw a system in place which identified those patients. Alerts on patient records helped inform clinicians where health checks were due and these were promoted opportunistically and when patients had not responded to invitation. On a monthly basis searches were run from the system so that reminders could be sent to patients. We looked at data which showed us that uptake of health checks had been positive.

The practice kept registers for patients with all long term conditions, diabetes, asthma, COPD and these were monitored through QOF to ensure that patients received all treatment and services they were entitled to. Smoking cessation figures had been lower than average and this had been addressed with clinicians asking the question during every patient consultation and recording that treatment had been discussed and offered.

Patients in a specific nursing home were visited weekly by a named GP from the practice. This enabled regular monitoring of the health of patients living at the home and reduced the number of requests for visits to deal with acute exacerbations of illness. All patients with mental health conditions were offered an annual review of their health and the treatment being provided and offered. Patients at risk of dementia were highlighted and offered opportunistic memory assessment. Patients with long term conditions were encouraged to make decisions about their treatment and were supported in self-management. Regular health reviews identified prevention, early diagnosis and positive interventions.

Good

Are services effective?

(for example, treatment is effective)

The TV in the waiting room provided lifestyle and practice information. The practice website also provided plenty of information around different ways of identifying and preventing conditions with signposting to various other support organisations. There was various information in the waiting room and around the practice on health conditions and signposting to outside organisations.

Good

Are services caring?

Our findings

We saw that reception staff were polite and friendly and treated staff with compassion and respect. We were told of incidents where reception staff had gone over and above requirements to help and support patients. Examples included helping patients to access services they may not have been aware of in relation to their illnesses. Patients reported that the medical and nursing staff were helpful and compassionate. All patients we spoke to said the practice offered an excellent service and that staff were efficient, helpful and caring. One or two long term patients mentioned that the service had improved over a number of years. Seven CQC comments cards were received and the comments about the dignity and respect were positive.

We observed that confidentiality in the waiting room was an issue. The waiting room was small and one of our inspection team was able to overhear conversations between patients and reception staff. Information overheard included one patient's name, address, telephone number, condition and medication. Structurally the issue was not within the control of the practice as major refurbishment had already been undertaken. However there was an opportunity for the practice to review training in this area and provide reception staff with different ways of obtaining information from patients. There was a room available for patients to speak in privacy and information in this respect was displayed. Despite that one of our inspection team overheard a discussion between practice staff and a distressed and agitated patient. One member of reception staff told us they had done training on how to deal with difficult patients but it was not clear whether all reception staff had received this training. The practice manager told us that reception staff had been trained on equality and diversity. Staff responded with different levels of understanding on the subject when questioned by the inspection team. Three patients we spoke to mentioned privacy was an issue and said the waiting room was too small.

Care planning and involvement in decisions about care and treatment

Patients were involved in decisions about their care and treatment and received information to help them in those decisions. All patients with multiple morbidities received an initial discussion about their treatment and preferred place of care and were given details of how to contact the surgery if they required urgent access. Care plans were provided to all those patients and were updated three monthly or sooner if necessary, such as when there were changes in circumstances.

We spoke with one of the nurses who was involved in the care planning of elderly patients in residential and nursing homes. The nurse reported that during discussions with these patients, end of life wishes were documented. Disadvantaged children in children's homes were also offered care plans where required. These were being implemented by the nurse practitioner.

Patient/carer support to cope emotionally with care and treatment

Nurses we spoke with provided examples of how patients are supported emotionally with care and treatment. We were told that if patients displayed depressive related symptoms following trauma or bereavement they would be referred to the GP who would either respond to their need or refer them on to outside services such as bereavement counselling. GPs told us of bereavement counselling services and hospice run groups which were available to patients at the practice.

Patients we spoke to reported that the staff were very supportive. Counselling and psychotherapy services were available within the Clinical Commissioning Group CCG and patients could be referred to those when required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients' needs and there were systems in place to maintain the level of service provided. GPs had lead roles for specific conditions such as dementia, diabetes, child health, joint injection, safeguarding, palliative care and chronic obstructive pulmonary disease (COPD). Nurses also held lead roles in chronic disease management and worked independently with input and GP expertise when required. There was a system in place to ensure that patients with long term conditions had regular appointments to review and monitor their conditions. Medicine reviews were arranged at appropriate intervals and regular health checks were offered and provided. Patients with complex needs had a named GP and the practice worked with other health and social care professionals to provide support.

Patients over the age of 75 had a named GP and proactive personalised care plans to reduce unplanned admissions to hospital. The practice participated in a range of locally enhanced services including dementia and end of life care and worked closely with local nursing homes. They had an arrangement with one of the nursing homes where a GP attended once a week and reviewed the patients who lived there.

Appointments were available outside of school hours for families with young children and the practice offered weekly child health surveillance appointments. All children under the age of two years was offered an appointment on the day it was requested. The practice liaised with the Bury lead GP about any child protection issues. There was a register of people living in vulnerable circumstances such as children's homes or those patients living in nursing homes with dementia or mental health conditions.

GPs engaged with the Clinical Commissioning Group (CCG) to discuss local needs and areas of priority. The practice also implemented suggestions for improvement and made changes to the way it delivered services in response to feedback from patients and the patient participation group. To respond to difficulty in accessing appointments the GPs introduced an additional clinical session and reduced planned periods of leave to one clinician at a time.

Tackling inequity and promoting equality

There was little diversity within the practice population but practice staff were aware of their responsibilities and reported that they would treat all patients equally. We discussed examples where language may be a barrier for a few patients. Reception staff knew about translation services available if required but said it was not frequently required. A member of nursing staff described how they would communicate with patients who did not speak English and knew that translation services were available. Staff had not received specific training in equality and diversity but the practice manager said that this had been covered under safeguarding.

The surgery had been recently modernised and adapted to meet the needs of patients with disabilities. It complied with the Disability Discrimination Act providing easy access via ramps outside the property and access to consulting rooms on the ground floors when required. The waiting area was large enough to accommodate wheelchairs and prams, an accessible toilet and facilities available for nursing mothers.

Access to the service

The building was open between the hours of 8am and 6pm from Monday to Friday and closed at weekends. The phone lines for the practice closed between 12.30pm and 2pm each day and an answer message provided emergency contact numbers. There was a minimum of six surgery sessions each day and surgery hours were 9am till 12.30pm and 3pm until 5.30pm daily. When the practice was closed an out of hours service was available and patients could access the Walk In Centre at evenings and weekends. The practice did not offer extended hours but patients could access a GP via the Bury federation extended working hours programme. Patients could be seen anywhere in Bury and had a choice of where they wished to go. The partner GPs reported that they were very happy with the out of hours provision and had never had any issues.

Patients were able to arrange appointments or order prescriptions in person, by phone or via the web, and were encouraged to provide feedback on the services offered. Appointments could be booked in advance or on the same day and telephone consultations with a GP or the advanced nurse practitioner (ANP) were available on request. Appointment reminders could be delivered to patients by text if they were prepared to provide their mobile telephone numbers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided a wide range of NHS services which included family and maternity services, a full contraceptive service, clinics to manage long term conditions, access to a weekly drug addiction service and some minor surgery procedures.

Listening and learning from concerns and complaints

There was a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Patients reported that they knew about the complaints procedure and that information was available and provided to them when needed. One patient told us of an issue they had and that it had been responded to appropriately with a satisfactory outcome. Patients we spoke with said they would refer any comments to the practice manager or any of the reception staff and felt comfortable and encouraged to do so.

We looked at a number of complaints received in the last 12 months and found they were dealt with satisfactory and openly. The practice reviewed complaints annually to detect themes or trends and shared these with the CCG. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Some of the staff we spoke with told us that they did not get feedback from patients about their care and were only involved in complaints if it related to them or their practice. If complained to, one member of staff told us they would apologise and try to resolve the issue with the patient. If that were not possible they would refer them to the practice manager to make formal complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a statement of purpose which promoted a caring and responsive service with good outcomes for patients. All staff we spoke with demonstrated this vision. Clinical staff particularly felt that the quality outcomes framework was not a tick box exercise and was there to improve outcomes for patients. The GPs had recently held a meeting to discuss the strategy for the practice over the next few years but this had not been formally shared with all the staff.

There were a number of newly employed staff at the practice and staff were becoming familiar with the patients and their level of need. They knew their responsibilities towards their patients and told us how they would put them in to practice. We were told that teams were the best they had ever been.

Governance arrangements

There were a number of policies and procedures in place to govern activity and staff we spoke with knew how to access them. They said they were available in paper format in the practice manager's office. We were told that policies for safeguarding were available in the reception area and infection control policies would be available via the nurse practitioner. The staff had access to a shared drive on their computers but policies and procedures were not available electronically. Some policies required review and update to be sure they reflected working practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it had improved performance and was in line with national standards in almost all areas. There were systems in place to ensure improvement continued.

The practice nurses had a good peer review system within the practice but there was little opportunity to network outside of the practice. Nurses had not been involved in any audits in the past twelve months. GPs had an ongoing programme of clinical audit which it used to monitor quality and systems and to identify where action should be taken.

Leadership, openness and transparency

The practice had undergone a period of considerable disruption following the departure of staff in lead roles. Lines of leadership had evolved and named members of staff had agreed to take lead roles. This structure was newly implemented and was, according to staff, beneficial. All staff we spoke to knew who the leads were for things such as safeguarding and infection control. They also knew who to speak to if they had any personal or work issues. The lead GP told us they offered an open door policy and staff spoken with corroborated this. They said they would feel happy to speak to any of the GPs or other member of staff in a senior position without discomfort or repercussion.

Practice meetings which involved all members of staff, or representatives from all disciplines, were not held regularly. There had recently been meetings between reception staff and GPs to identify any issues and take action to resolve them. They had reported that this had been effective. Nursing staff reported that one of the GPs was taking a lead to improve communication and information sharing between the nursing and medical staff.

We discussed induction, the management of sickness and disciplinary procedures with a member of staff. They said they understood their responsibilities and were aware of protocols for whistleblowing or raising concerns. They were able to access policy and procedure via their staff handbook.

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

The practice had gathered feedback from patients through avenues such as Family and Friends survey, internal patient surveys, a suggestion box, comments and complaints and the patient participation group (PPG). The PPG worked very hard to encourage membership, increase awareness and reached out to younger patients and those in vulnerable circumstances to request their involvement. The GPs and practice manager met with the PPG and collated minutes from those meetings.

Recent issues identified by the PPG related to privacy and space in the practice waiting room and the attitude of reception staff. The practice manager was in discussion with the landlords about the privacy and space issues but proposed meetings had been deferred due to unforeseen

Are services well-led?

Good

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

circumstances. Reception staff had however received training in customer care and now identified themselves to patients by wearing name badges and when speaking to them on the telephone.

Other areas which had been addressed in the past included increased telephone access, more telephone consultations, and the ability to make appointments via the website. A survey had shown that this had produced positive results with an increase from 39% to 60% of patients reporting that it was easy to get through to the practice on the telephone.

Several topics had been addressed over the past years including increased telephone access, more telephone consultations, and more appointments made available on the website. Patients could book appointments and order prescriptions via the practice website and 74% of patients surveyed agreed that this was very easy to use. The PPG had also influenced the major refurbishment that had been carried out to the premises.

Management lead through learning and improvement

The practice did not train junior medical staff but they offered temporary posts to asylum seeker GPs who could gain experience and improve their English prior to sitting their Professional and Linguistic Assessments Board Test (PLAB). GPs attended clinical cabinet meetings where they discussed examples of patient care and shared information of relevance about their clinical practice in order to learn and improve their services and patient outcomes.

Some learning time initiatives had been set up during lunch time periods when the telephone lines were closed to discuss patient scenarios and share learning. Reflections about best practice was mainly done in teams of staff discipline such as reception, administration, nursing or medical rather than between all staff members.

The GPs gave each other peer support, discussed issues, shared learning and identified areas that required further education. Recently they had invited a community paediatric dietician to present a meeting and discuss the issues of cow's milk protein allergy and lactose intolerance in infants. This had highlighted a need for support from dieticians during the weaning process of infants onto products that contained milk.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Systems to ensure the proper and safe management of medicines were not effective;** **Regulation 12(g)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider's recruitment policy did not include a requirement for Disclosure and Barring Service (DBS) checks, a full employment history, explanation of gaps in employment and a procedure to follow if a staff member had a criminal record. Evidence of all required documentation as set out in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was not retained for all members of staff.** **Regulation 19(3)**