# Greenbank Medical Practice

## Quality Report

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Date of inspection visit: 03/06/2016
Date of publication: 11/08/2016

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

# 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 Greenbank Medical Practice on 3 June 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment and actions identified to address concerns with infection control practice had not been taken..
- Not all staff, including GP partners were clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with all relevant staff.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Most patients told us they could access appointments when required, and we saw some evidence of flexibility within the appointments system.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

# Summary of findings

- The provider must ensure patients are treated with dignity and respect. This includes being offered a chaperone when having an intimate examination and ensuring appropriate interpreters are used so patient confidentiality is maintained.
- The provider must ensure the procedure for making complaints is brought to the attention of patients and staff. Complaints must be shared appropriately to ensure learning and people making a complaint should be advised what action they can take if they are unhappy with how their complaint has been dealt with.
- The provider must ensure there is a system in place to monitor, assess and improve the quality and safety of the service.
- The provider must actively seek the views of patients about the quality of the care and treatment they receive.
- The provider must ensure all identified risks related to the prevention and control of infection are acted on.
- The provider must ensure all appropriate employment checks are carried out prior to employing staff. There must be a system in place to ensure all GPs and nurses have up to date registration with the appropriate professional body.
- The provider must ensure all staff have received appropriate clinical and mandatory training. A record must be kept of this training and it must be monitored.
- The provider must ensure all staff have regular supervision and appraisals.
- The provider must ensure all partners have an understanding of relevant issues relating to the running of the practice.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

**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?**

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Not all staff, particularly GP partners, were clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not widely communicated and so there was no assurance safety would be improved.
- Patients were at risk of harm because systems and processes were not always in place in a way to keep them safe. For example it had been recognised that infection control checks should be carried out in the treatment room following minor surgery, but these checks had not commenced.
- There was insufficient attention to safeguarding children and vulnerable adults. Although policies and procedures were available there was no system in place to ensure all clinical and non-clinical staff had received the appropriate level of training. Safeguarding was not routinely discussed in meetings so not all clinical staff were aware of incidents.
- Pre-employment checks were not always adequately carried out. This included locum GPs. For example a practice nurse had been employed without an up to date Disclosure and Barring Service (DBS) check being in place. The practice did not routinely check if practice nurses and GPs had up to date registration with the appropriate professional body.
- Chaperones were not routinely offered to patients having an intimate examination. A female clinician told us they never offered a chaperone to female patients, but would arrange one if it was requested.

**Are services effective?**

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others either locally or nationally.
- There was minimal engagement with other providers of health and social care.

# Summary of findings

- Training for staff had not been monitored and no training evidence was kept. There was no record of clinical training for GPs, and where a training record existed for staff we saw gaps in mandatory training.
- The practice's uptake for the cervical screening programme was 78%, which was below the CCG and national average of 82%.
- New patients were not routinely invited for health checks. NHS health checks were carried out by practice nurses, often on an opportunistic basis. There was no information about how many patients had attended a health check.

**Are services caring?**

**Inadequate**

The practice is rated as inadequate for providing caring services and improvements must be made.

- Information for patients about the services provided was available but not everybody would be able to understand or access it. For example, the practice told us there was a high number of patients who did not speak English as a first language. Information in the waiting room was in English.
- Interpreters were not used consistently. Two GP partners told us they frequently required interpreters who spoke Urdu and Punjabi. They did not use formal interpreters though and relied on relatives or other patients who were in the waiting room to provide the service.
- It was unclear what support was offered to bereaved patients. The practice manager told us these patients received a sympathy card and at times a telephone call from their GP, but a GP told us this did not take place.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- The majority of patients said they were treated with compassion, dignity and respect.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for providing responsive services and improvements must be made.

- Although the practice had reviewed the needs of its local population, it did not always adequately meet these needs. For example, GPs often relied on relatives to interpret during consultations and on occasions other patients were used.
- Feedback from patients reported that urgent appointments were usually available, and we saw that some flexibility in the appointment system was offered.

# Summary of findings

- There was no information in the waiting area informing patients how they could complain. Responses to complaints did not include where patients could refer their complaint to if they were not satisfied. There was no evidence that learning from complaints had been shared with staff.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a clear vision and strategy.
- There was no clear leadership structure.
- The practice had a number of policies and procedures to govern activity, but these were not always followed.
- The practice held regular meetings for different staff groups but no staff group had a full understanding of the practice.
- The practice had not proactively sought feedback from patients. They had a large virtual patient participation group (PPG) which they issues newsletters to, but they had not asked the group for feedback since the merger of the three practices.
- Not all staff received regular performance reviews. One GP told us their appraisal was overdue and the nurse practitioner told us they had not had a formal appraisal for nine years.

# 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

**Inadequate**

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Housebound patients were not coded on the practice's computer system. However staff told us they were aware of which patients were housebound and arranged home visits accordingly.
- There was a register of patients requiring palliative care, but we found this was not accurate.
- Each care home in the practice area had a nominated GP to provide continuity of care.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with local and national averages.

### People with long term conditions

**Inadequate**

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Home visits were available when patients needed them, although these patients were not coded on the computer system.
- Nursing staff had lead roles in chronic disease management, working closely with GPs.
- Patients at risk of hospital admission were discussed during bi-monthly multi-disciplinary meetings.

### Families, children and young people

**Inadequate**

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

# Summary of findings

- There was no evidence that all staff had been trained in safeguarding children, or been trained to the appropriate level.
- Safeguarding was not routinely discussed in meetings, with clinicians telling us it was only discussed with staff directly involved.
- Childhood immunisation rates were in line with the local and national average.
- Appointments were available outside school hours, with late night appointments being available once a week.

**Working age people (including those recently retired and students)**

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- Health checks for newly registered patients were not routinely offered.
- Cervical screening rates were below the local and national average. Not all GP partners were aware of this.
- Practice nurses carried out NHS health checks for patient aged over 40. This was often done opportunistically and there was no data about the number of patients who had attended.

**People whose circumstances may make them vulnerable**

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive services. The issues identified as requiring improvement overall affected all patients including this population group

- There was no evidence that all staff, including clinicians, had received training in safeguarding vulnerable adults.
- A Disclosure and Barring Service (DBS) check was not carried out for all appropriate staff prior to them being employed.
- There was no information available about support groups for vulnerable people in the area. Carers could be identified but routine health checks for carers were not arranged.
- There was no consistency in providing interpreters for patients who did not speak English as a first language. When an interpreter was arranged it was not normal practice to allocate extra appointment time.

# Summary of findings

**People experiencing poor mental health (including people with dementia)**

Inadequate 

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for providing safe, effective, caring and well-led services, and requires improvement for providing responsive services. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice.

- Clinical staff had a good understanding of consent and the Mental Capacity Act 2005.
- The percentage of patients with dementia who had had a face to face review of their condition within the previous 12 months was above the local and national average.
- GPs could refer patients for counselling. There was also counselling available in Urdu and Punjabi.

# Summary of findings

## What people who use the service say

The latest national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 401 survey forms were distributed and 98 were returned. This was a 24% completion rate representing just under 1% of the practice's patient list.

- 78% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group average of 72% and the national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and the national average of 85%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 19 comment cards and these contained mostly positive comments about the standard of care received. Patients said staff were pleasant and caring, and GPs gave good explanations to patients. Patients said they felt listened to, and the commented the practice was clean. Some patients commented that that they were kept waiting after their appointment time, and others said it could take a while to access an appointment with the GP of their choice.

We spoke briefly with four patients during the inspection. One patient told us they had been able to attend the practice as soon as it opened, and they were given an appointment to see a GP. Another said they had attended on the wrong day but the reception staff had made sure they were still seen. The patients told us they were satisfied with the care they received and thought staff were caring.

## Areas for improvement

**Action the service MUST take to improve**

- The provider must ensure patients are treated with dignity and respect. This includes being offered a chaperone when having an intimate examination and ensuring appropriate interpreters are used so patient confidentiality is maintained.
- The provider must ensure the procedure for making complaints is brought to the attention of patients and staff. Complaints must be shared appropriately to ensure learning and people making a complaint should be advised what action they can take if they are unhappy with how their complaint has been dealt with.
- The provider must ensure there is a system in place to monitor, assess and improve the quality and safety of the service.
- The provider must actively seek the views of patients about the quality of the care and treatment they receive.
- The provider must ensure all identified risks related to the prevention and control of infection are acted on.
- The provider must ensure all appropriate employment checks are carried out prior to employing staff. There must be a system in place to ensure all GPs and nurses have up to date registration with the appropriate professional body.
- The provider must ensure all staff have received appropriate clinical and mandatory training. A record must be kept of this training and it must be monitored.

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- The provider must ensure all staff have regular supervision and appraisals.
- The provider must ensure all partners have an understanding of relevant issues relating to the running of the practice.

# Greenbank 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 also included a GP specialist adviser.

## Background to Greenbank Medical Practice

Greenbank Medical Practice is located in purpose built premises approximately one mile from the centre of Oldham. It is a two storey building with patients currently having access to the ground floor. There is a large car park and disabled parking is available.

At the time of our inspection there were 10,259 patients registered with the practice. The practice is overseen by NHS Oldham Clinical Commissioning Group (CCG). The practice delivers commissioned services under the General Medical Services (GMS) contract.

There were originally three GP practices in the building. Two practices, Glodwick Medical Practice and The Radcliffe Medical Practice merged in April 2014 to form Greenbank Medical Practice. In October 2015 The Addy Practice also merged with Greenbank Medical Practice.

There are five GP partners, two male and three female. There are also three regular locum GPs, two male and one female.

There is a nurse practitioner, four practice nurses, two healthcare assistants, a practice manager, a business manager, and reception and administrative staff.

The practice gender profile is similar to the national averages. There is a higher than average number of patients under the age of 14, and a lower than average number of patients over the age of 50. Life expectancy is slightly under the CCG average, and there is a higher than average number of patients with a long term condition. The practice is in the most deprived decile.

Normal opening hours are 8am until 6.30pm Monday to Friday. The practice opens until 7pm every Tuesday, and until 8pm every other Tuesday. Appointments are available from 7.30am three times a week and these days vary. The practice closes at 1pm on the last Wednesday of every month.

There is an out of hours service available by phoning NHS 111. The out of hours provider is Go To Doc.

The practice is a teaching practice for fourth year medical students, and a medical student usually attends the practice once a week.

## 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. The 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.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 June 2016. During our visit we:

- Spoke with a range of staff including three GP partners, the nurse practitioner, two practice nurses, a healthcare assistant, the practice manager, the business manager and administrative and reception staff.
- Spoke briefly to patients in the waiting area.
- Observed how patients were spoken to in the reception area.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed a range of policies and procedures.

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 were provided for specific groups of people and what good care looked 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).

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.

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system in place for reporting and recording significant events (SEAs). The practice manager told us that the system had been put in place in October 2015 when the most recent merger had taken place. They said that due to this change GPs who had not previously completed a significant event form would not know how to locate or record SEAs.

- Reception and administrative staff told us they knew how to report significant events, and they knew where to find a record of past SEAs.
- The GP partners we spoke with had different understandings of the SEA procedure. They did not all know where to locate the forms to record SEAs. One did not know where the records of previous SEAs were kept. One GP told us they could not recall when the last meeting was held where an SEA was discussed.
- The practice manager told us there was no formal review of SEAs to ensure incidents had not been repeated. However, they completed an annual return for the clinical commissioning group (CCG) and said they would spot any recurrences then.
- The practice manager told us that whoever completed the SEA form would decide if it should be discussed at a practice meeting. If one of the administrative staff completed the form they would bring this up at an administration meeting if they felt it was required.
- There was no formal process for discussing and sharing learning from SEAs; it was left to individual staff members to decide the next step.

**Overview of safety systems and processes**

The practice did not have defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. For example:

- The nurse practitioner and a GP partner were the safeguarding leads for the practice, and most staff were aware of this. There were safeguarding policies in place for children and adults. The safeguarding children policy stated the practice would arrange annual training for staff. The GP partners we spoke with told us they had been trained but two did not know what level they had been trained to. We saw no evidence of safeguarding training for GPs and the practice told us they thought GPs had been trained but they did not usually keep evidence of GP training. Evidence of safeguarding training of any level was not available for six of the twelve administrative staff and for four of the five nurses. The staff we spoke with told us information about how to report concerns was available in a shared folder on the practice's computer. Information was also on the notice boards of consulting rooms. Two of the three GP partners we spoke with told us they were not aware of any safeguarding referrals in the previous 12 months, but the nurse practitioner showed us evidence of a safeguarding concern being referred to a social worker in February 2016. We were told safeguarding was not discussed in clinical meetings, but was discussed separately with the people it concerned.
- A notice behind a disused reception desk advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). GPs told us they used nurses as chaperones if they were available, but one nurse had provided an old DBS check when they started work. Evidence of this had not been kept. The practice manager told us they had intended to request a new DBS check but this had only just been done, and the check had not been returned. One practice nurse told us they offered patients a chaperone for intimate examinations but no-one had ever accepted one. The other practice nurse told us they never offered a chaperone to patients as they never carried out intimate examinations on patients of the opposite gender. They said they did not offer a chaperone to a female patient if they were carrying out a cervical smear, but if a patient requested one they would arrange it.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy.
- The infection control policy stated that all staff would receive annual infection control training. However, training records showed that not all staff had received training, and it was not always updated for those that

were trained. The policy stated a bi-monthly unannounced infection control inspection would take place by one of the staff named in the infection control policy. We saw that an infection control audit had been carried out in May 2016. This was by the practice manager who was not named in the policy. The audit had highlighted that new flooring was required in some rooms, and this had been arranged for July 2016. The practice manager told the inspection team of a new check list was implemented following all minor surgery clinics; we did see a copy of the check lists however these were blank. When we asked to see a completed sheet there was none available. The practice used fabric privacy curtains in the surgeries. There was no system in place to ensure these were regularly laundered, and we saw they had last been laundered in October 2014.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- We reviewed the personnel file of the most recent staff member to be recruited, in May 2016. We saw that a full employment history was provided and references had been sought. Evidence of identity was kept. The practice manager told us they had requested a DBS check and the staff member would not chaperone until this had been returned. We also reviewed the file of the most recently recruited practice nurse, who joined the practice in December 2015. The practice manager told us they saw an old DBS check for the practice nurse and had intended to request an up to date check. This had only just been requested and had not been returned. There was no evidence that any DBS check had been seen. There was no system in place to check the professional registration of nurses was up to date. The business manager was responsible for checks relating to GPs and locum GPs. They told us they used to have personnel files for the GP partners but these could not be located. They told us there were no checks to ensure GPs were registered with the appropriate professional body. GP partners and the practice manager told us that all GP partners were responsible for taking out their own insurance. They kept this at home and there were no checks carried out at the practice to ensure all GP partners were adequately insured.
- The business manager told us they had three regular locums. We saw the information held for them and found that not all the required information was held. There was no system in place to ensure the required checks had been carried out. Following the inspection the practice provided further information about the locum GPs.

**Monitoring risks to patients**

Risks to patients were assessed and but not always managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the office which identified local health and safety representatives. The practice manager told us the Primary Care Trust (PCT) had carried out all their safety checks but these stopped when the PCTs were replaced by CCGs in April 2013. They had now put their own safety checks in place and checks such as for the means of escape and emergency lighting were being carried out.
- The practice had carried out their own fire risk assessment in March 2016. A contractor had carried out a legionella risk assessment and checks in February 2016. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had not been able to carry out the required monthly checks after this as they needed to purchase a piece of equipment in order to do this. We saw that portable electrical appliance testing had been carried out in November 2015, and equipment such as medical scales was calibrated on this date.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty, and this was managed by the practice manager. A partner had left in October 2015 and the practice was hoping to recruit another permanent GP. They told us the locum GPs had been at the practice 18 months and they increased their hours to manage this.

Inadequate

# Are services safe?

**Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice manager told us all staff received annual face to face basic life support training. However, evidence of this was not available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a room off the main corridor. All staff knew of their location. The room was not kept locked and was accessible to patients who could then access the medicines. The practice manager told us the room was unlocked to ensure easy access but there was no formal risk assessment where the accessibility of medicines to patients had been considered.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice manager told us they emailed alerts to GPs and they were saved in a shared folder. They said GPs looked at guidance on the Internet and if appropriate they requested they were discussed at meetings. We saw an example of NICE guidance being discussed in meetings, and practice nurses told us they also discussed updates and guidance. One GP partner told us there was no formal dissemination of new NICE guidelines and they were discussed on an ad-hoc basis. They said there was no formal process to ensure locum GPs adhered to best practice guidelines.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96.9% of the total number of points available. The clinical exception rate was 3.9%, which was below the CCG average of 6.8% and the national average of 9.2%. Exception rates ensure practices are not penalised, for example when patients did not attend for a review or they cannot prescribe a certain medicine due to a side effect.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed:

- Performance for diabetes related indicators was 90.8%. This was better than the local average of 81.8% and the national average of 89.2%.
- Performance for mental health related indicators was 98.1%. This was better than the local average of 91.7% and the national average of 92.8%.

  There had been a further practice merger following these QOF results.

  We did not see evidence of quality improvement arising from clinical audits.

- The practice showed us an asthma audit completed in March 2015 and reviewed in June 2015. This stated it would be reviewed again in three months and then every six months. No subsequent audits were available and the GP we asked was unaware of it.
- One GP told us they were unsure what clinical audits had been carried out at the practice. They said individual GPs carried out their own audits for appraisal purposes and stored them themselves. Another GP told us they were not aware of any clinical audits being carried out in the past year.
- The practice manager told us GPs would not know where to access clinical audits as they left that to the practice manager and business manager.

Patients with a long term condition had an annual review, usually carried out by a practice nurses. Practice nurses told us they worked well with GPs when they carried out the reviews. There was an alert on the practice's computer system when a patient with a high risk of an unplanned hospital admission contacted the practice. These patients were always seen on the day they requested an appointment.

The practice had a register of patients requiring palliative care. We saw that 71 patients were on this list. We looked at two entries at random and neither patient required palliative care; they had been incorrectly coded.

GPs were alerted when a patient had attended the local A&E department. We saw evidence that the information was reviewed daily and GPs contacted patients where they thought an appointment or discussion would be beneficial.

The practice was one of two practices in Oldham who were part of the zero tolerance scheme. This was for patients who had been removed from the list of other practices in Oldham due to the zero tolerance of abuse or aggression policy. These patients were usually seen during lunchtime when the practice was quieter. A longer appointment, usually of 30 minutes, was provided. Patients were colour coded so reception staff knew what type of appointment to offer. For example, some patients benefitted from being seen when no-one else was in the practice.

**Effective staffing**

There was no assurance that staff had the skills, knowledge and experience to deliver effective care and treatment.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered information about their job roles and the practice. It also included information about training new staff must complete, including safeguarding, fire safety, health and safety and confidentiality. We spoke with a staff member who had recently been recruited. They told us this training would be completed following their two week induction period where they were made aware of their role.
- We were unable to identify if all staff had received basic life support training. We were assured by the practice manager all staff had received this training but no evidence could be provided to the inspection team.
- The practice manager had collated all the training, both on-line and face to face training, carried out by staff and included it on one document so it could be monitored. They told us they were now reviewing the document so they could see what training was outstanding for staff. They intended to then review it each month and prompt staff when their training was due. They said staff were given administration time in work to complete their training.
- We reviewed the training information held for staff. There was no training information held for some staff, including four of the five GP partners, the nurse practitioner and two of the four nurses. The practice manager told us some GPs arranged their own training so the practice did not know what they had completed. The training information held for one GP partner and two nurses did not include any clinical training. The training record showed other staff had not completed mandatory training such as safeguarding or fire safety.
- Most staff had had an appraisal within the previous 12 months. However, one GP partner told us they were overdue their appraisal and their last one had been 13 months ago. The nurse practitioner told us they had never had a formal appraisal in the nine years they had worked at the practice. However they told us they felt they received support when needed. The practice manager told us that they worked closely with the business manager. They had therefore decided they would carry out each other's appraisal but have input from at least one GP. They did not know who this would be. Performance objectives were set for staff each year. These were reviewed the following year at their next appraisal.
- Not all staff were of aware who their line manager was. They said that before the most recent practice merger they had a line manager but since the merger the practice manager and business manager had different roles.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice manager told us meetings took place with other health care professionals on a bi-monthly basis. Patients at a higher risk of an unplanned hospital admission had their care plans reviewed at these meetings and the care of patients receiving palliative care was also reviewed. The practice manager told us Macmillan nurses attended the meetings but district nurses often didn't. We asked a GP partner about meetings held to discuss end of life care but they were unaware of the frequency of these.

**Consent to care and treatment**

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The nursing staff we spoke with understood issues around consent and the Mental Capacity Act 2005. However one GP partner told us they did not know how they were assured nursing staff understood these issues,

and another GP partner told us they were unaware of any recent training. The practice manager told us they thought staff had received on-line training, but training records did not provide this evidence.

**Supporting patients to live healthier lives**

It was unclear how the practice identified some patients who may be in need of extra support. For example:

- There was a register of patients receiving end of life care. However, when we reviewed this some patients had been incorrectly coded.
- We saw that the practice's computer system alerted staff if a patient was a carer. However, carers' health checks were not routinely offered, and there was no formal support offered to carers unless they had a long term condition.
- Patients who would benefit from weight management advice or smoking cessation advice were referred to a local service.
- A drug and alcohol worker attended the practice once day a week plus every other Friday. GPs could refer patients to this service.

The practice's uptake for the cervical screening programme was 78%, which was below the CCG and national average of 82%. We asked a GP what action was being taken to improve these figures and they told us this was dealt with by the practice manager. The practice manager told us they tried to telephone patients who did not attend for a cervical smear test, but it was difficult due to the ethnic mix of the practice population. They thought patients did not understand the importance of the test and therefore would not have it carried out. Practice nurses told us they reminded patients of the importance of cervical smears when they attended baby immunisation clinics and if they attended for another reason they would offer opportunistic tests if possible.

Childhood immunisation rates for the vaccinations given were comparable to the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 75.4% to 77.7% (slightly above average) and five year olds from 66.7% to 68.2% (slightly below average).

New patients were not routinely invited for a new patient health check. The practice nurses explained they reviewed new patient registration forms and if a patient had a long term condition they were invited for a review. The nurses carried out a general health check during this review. They said that if the registration forms indicated an issue, for example high alcohol consumption, patients would also be invited in. Nurses also carried out NHS health checks for patients aged 40 to 74. These were often carried out on an opportunistic basis, and there was no record of how many patients had attended. Health checks were also carried out for patients over the age of 75.

There was a patient health pod in the waiting room. Instructions were in English, Urdu and Romanian. The health pod measured patients' blood pressure. There was the facility for this information to be transferred direct into the patients' medical record so a record could be kept and appropriate action taken.

Inadequate

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and helpful to patients.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Sixteen of the 19 patient Care Quality Commission comment cards we received were wholly positive about the service experienced. Patients said GPs gave them enough time, they did not feel rushed, and they felt GPs listened to them. Two patients commented that it could take a long time to see the GP of their choice, and that appointments were often running late. Another patient said they preferred to see the GP they were registered with as they felt others did not hear their concerns with the dignity and respect required.

The latest national GP patient survey were published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was usually above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Patient feedback from the comment cards we received was mainly positive. Patients commented that the practice was caring and GPs explained things to them well.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice did not always provide adequate facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. They told us a large percentage of patients did not speak English as a first language but they were unaware of the numbers. They thought approximately 40% of patients were from Pakistan but were unsure how many did not speak English, and they also said there was an increasing number of Eastern European patients who did not speak English. However, the use of interpreters was not consistent. One GP partner told us they used interpreters for Hungarian speakers but for languages such as Urdu and Bengali they relied on patients to bring relatives. They said that at times patients went out

of their consultation to get a patient who was not known to them from the waiting room who could interpret for them. They told us that other than for Hungarian speakers they had not used a formal interpreter for over a year. The GP did not show insight that this was a breach of patient confidentiality and dignity. Another GP partner told us they had not used a formal interpreter for about a year but they did use family members who attended with patients daily.

- Information leaflets were available in the waiting room in English. We saw examples of leaflets for specific medical conditions being available in other languages. These were provided by GPs.

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 122 patients as carers (1.2% of the practice list). A GP told us here was no formal support offered to carers, except if they had a long term condition. They then told us carers were screened on an opportunistic basis. The practice website gave information about services for carers in the Oldham area.

The practice manager told us counsellors attended the practice every Monday and Tuesday, but one of the GPs we spoke with was not aware of this. A 'first language' counselling service had been set up in the area four months ago for patients who did not speak English as a first language. This was predominantly for Punjabi or Bengali speakers and the practice manager was not aware of a waiting list.

The practice manager told us the practice sent a sympathy card to bereaved families, and if a GP noticed a patient had died they telephoned the family. They said that counselling was offered if appropriate and there was a telephone number on the website for bereavement support. However, when they checked this number could not be located. We asked a GP about support for patients following a bereavement. They said they did not send sympathy cards and they did not routinely offer appointments to bereaved patients. Following the inspection the practice manager told us it was the senior receptionist who sent out bereavement cards on behalf of the GPs.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice had reviewed the needs of its local population and made some changes to services in line with these needs. However not all services were appropriate.

- The practice offered late night opening until 7pm on Tuesdays, with opening until 8pm every other Tuesday. Appointments were available from 7.30am three times a week.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Housebound patients were not coded on the computer system but the practice manager told us they were aware who was housebound.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice was accessible to disabled people, and improvements were being made to the front entrance to make it easier for patients using wheelchairs or pushing prams. There was a hearing loop.
- Patients had access to the ground floor only. However, building work was in progress and the nursing team were going to move to the first floor. There was a passenger lift available.
- The practice told us they initiated a scheme within their cluster of GP practices where patients could receive information about diabetes in their own language. There were male and female only groups and courses were available in Urdu, Punjabi and Bengali. The courses ran for seven weeks and the first course was just coming to an end so evaluation had not yet taken place. Information about Asian cooking, shopping and food labels was included in the course, and the practice manager told us feedback so far was positive.
- The practice told us that they had a large black and minority ethnic (BME) practice population that they estimated to be 40% of their patients, and a growing number of patients spoke Eastern European languages. They were unsure how many of these patients did not speak English as a first language. Use of interpreters was not consistent and GPs often relied on family members or other patients to translate during a consultation. Two GPs told us they had not used formal interpreters for languages such as Urdu or Bengali for about a year. No additional appointment time was given when a formal interpreter was used. The practice manager told us they did not feel additional time was required as appointments were 15 minutes long.

**Access to the service**

The core opening hours were 8am until 6.30pm Monday to Friday. The first appointment was 8am and the last 6.15pm. The practice opened late every Tuesday. It was open until 7pm (last appointment 6.45pm) one week and 8pm (last appointment 7.45pm) then following week. Appointments were also available from 7.30am three times a week. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice manager told that most appointments were released at 8am daily. However a smaller number were released at 12.30pm. They said that if all the morning appointments had been taken patients were asked to phone back at 12.30pm. Young children would be given an appointment without phoning back. We checked the available appointments at 11.42am during the inspection. We saw patients could access routine appointments in four working days' time. There were no emergency appointments available but the practice manager told us this would change if a patient telephoned at 12.30pm.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 75%.
- 78% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. We saw one patient arrive at the practice as soon as it opened as

they felt unwell. They were given an appointment with a GP within a few minutes, and they told us they could always be seen when needed. We saw another patient had attended on the wrong day. They were also seen after a short wait.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns.

- Its 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.
- There was no information in the waiting room to inform patients how to make a complaint. The practice manager told us a leaflet was available if patients asked at the reception desk.

We saw four written complaints had been recorded in 2015-16. We looked in detail at the two received since the most recent merger in October 2015. These had been investigated and responded to. The final responses did not inform people they could refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if they were unhappy with how their complaint had been handled. The practice manager told us they did not usually include this information, but we saw the policy stated this should happen. Verbal complaints were recorded separately.

One of the GPs we spoke with told if a patient made a verbal complaint they were told to put it in writing. Another GP told us they were not aware of any complaints being made since October 2015. The practice manager told us complaints were discussed in meetings under the heading 'any other business' but no details were recorded in meeting minutes. They said all staff had access to the shared complaints folder so they should be aware of any complaints made.

# Are services well-led?

Inadequate

(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 mission statement but not all staff were aware of this. One of the GP partners told us the practice manage dealt with the practice values.

**Governance arrangements**

The practice did not have a governance framework to support the delivery of good quality care:

- The staffing structure was unclear with some staff not knowing who their line manager was.
- Since the most recent practice merger in October 2015 new policies had been put in place. However the procedures in some policies, such as the infection control policy and the complaints policy, were not being followed.
- A comprehensive understanding of the performance of the practice was not maintained. GPs were unaware of some issues, such as cervical screening rates. The practice manager told us the GPs were very good at clinical issues and left the practice manager and business manager to manage other areas of the practice.
- There was no programme of continuous clinical and internal audit so no evidence audits were used to monitor quality and to make improvements. GPs told us they completed their own audits for appraisal purposes and they kept these themselves. They were not shared and GPs were unaware of audits they had not carried out themselves.
- There were no robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

**Leadership and culture**

On the day of inspection the partners in the practice did not demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. Two practices had merged in April 2014, with a third practice merging with them in October 2015. We spoke with three of the five partners, and they had been a partner in the practice or a merging practice for a minimum of seven years. The partners we spoke with were unaware of many aspects relating to the management of the practice. For example one GP was unaware how to access the form to report significant events and another was unaware of any complaints that had been made. The practice manager told us one partner had all the relevant information available and it had been planned that they would be present during the inspection to talk to inspectors and answer any questions. However due to unforeseen circumstances they had not been able to attend and they had not realised other partners would not have the required knowledge and information.

The provider did not have systems in place to identify when consideration of compliance with the duty of candour may be required. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Not all staff, including GP partners, were aware of safety incidents and how to record them, and there was no system in place to routinely discuss significant events.

There was no clear leadership structure in place.

- Staff told us the practice held regular meetings. GP and nurse meetings were held once a month and the reception and administrative team also met monthly during the half day closure. The practice manager told us they had held full team meetings in the past but it was found that meeting in different staffing groups worked better. However, we found that this meant staff groups did not have a wider understanding of the practice. Partners also did not have full understanding of the practice or how each other worked.
- Staff told us they were able to approach the partners if they had an issue, and they found the practice manager supportive.

**Seeking and acting on feedback from patients, the public and staff**

The practice did not proactively seek patients' feedback and engage patients in the delivery of the service.

- The practice had a large virtual patient participation group (PPG). Since the merger the practice had sent out newsletters to the PPG but had not proactively asked them for their opinions of the practice or involved them in elements of the practice.

# Are services well-led?

Inadequate

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

- The practice manager told us they tried to look on the NHS Choices website every month. However, since the merger they no longer received alerts when a patient left feedback.
- There was a suggestions box in the waiting room, but no paper or pens were provided. The business manager told us they checked the box but not often, approximately every month. They told us patients tended to tell them verbally if they had any suggestions. If this was regarded as an informal complaint it was recorded.

**Continuous improvement**

We saw little evidence of any focus on continuous learning and improvement within the practice. The practice told us they initiated a scheme within their cluster of GP practices where patients could receive information about diabetes in their own language. There were male and female only groups and courses were available in Urdu, Punjabi and Bengali. The courses ran for seven weeks and the first course was just coming to an end so evaluation had not yet taken place. Information about Asian cooking, shopping and food labels was included in the course, and the practice manager told us feedback so far was positive.

The practice was a teaching practice and fourth year medical students attended one day a week. We saw that feedback from the university was positive at all levels within the practice.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>The provider did not ensure all staff were aware of the complaints procedure and that complaints did not have to be put in writing. Complaints were not widely discussed so not all GP partners were aware of complaints that had been made, and learning from complaints was not assured. There was no information available in the waiting room to inform patients how to make a complaint. When a complaint was responded to the provider did not inform the complainant how they could take action if they were not satisfied with how their complaint had been dealt with.<br><br>This was in breach of regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider did not have assurance that all staff were suitably qualified and skills to perform the duties for which they were employed. Training records held identified gaps in clinical and mandatory training, and no training information was kept for some staff including clinical staff. Not all staff had had an appraisal in the previous 12 months with one clinician stating they had had no formal appraisal for during the previous nine years.<br><br>This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

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 did not ensure an up to date Disclosure and Barring Service (DBS) check was carried out for all appropriate staff before they started work. There were no routine checks in place to ensure clinicians had continued registration with the relevant professional body.

This was in breach of regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Enforcement actions

## 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 |
|---|---|
| Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>The provider did not ensure a chaperone was offered for all intimate examinations.<br><br>The use of interpreters was not consistent. Formal interpreters were used for some languages but for others GPs relied on the family members of patients or unrelated patients in the waiting room to act as interpreters. This did not ensure patient confidentiality or the dignity of patients.<br><br>This was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have systems and processes in place to ensure compliance with the regulations. There was no system in place to monitor, assess and improve the quality of the service. The provider did not ensure all identified risks relating to the prevention and control of infection were acted on. The provider did not actively seek the views of patients about the quality of the care and treatment they received.<br><br>This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |