# Jarvis Medical Practice - GPCC

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Jarvis Medical Practice on 4 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the 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 and people experiencing poor mental health (including people with dementia.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available to patients.
- Patients said they found it easy to make an appointment with a named GP and 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.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients.
- The practice have a good understanding of the cultural needs of patients, for example, providing guidance and support to people with diabetes.

We saw several areas of outstanding practice including:

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- The practice worked closely with the local community to promote health awareness. They worked closely with local community groups to ensure healthcare information reached groups of patients from black and minority ethnic communities. The GP worked closely with the local mosque and regularly spoke at information sessions to groups of the community on topics such as diabetes, forced marriage and domestic violence.
- The practice was committed to health promotion and prevention with a strong emphasis on improving patient's well-being and lifestyle. The GP was working with Public Health England on providing dietary advice for patients who followed an Asian diet and the implications this might have for people's diabetes condition. They also presented a weekly programme on Sky television to Pakistan and to the local Pakistani community in Oldham.

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

The provider should:

- A programme of more frequent clinical audits should be developed to demonstrate positive outcomes for patients.
- Pre-employment checks should be in place before staff are employed.
- A training record of all staff employed or contracted to work sessionally at the practice should be kept, for example, nurses, GPs and locum GPs.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

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

**Are services effective?**

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. There was limited use of clinical audits and how these were used to improve patient outcomes.

**Are services caring?**

Good

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

**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. Patients said they found it easy to make an appointment with a named GP and 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.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their

# Summary of findings

responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. The practice kept a register of those patients over 75 years of age and all patients of this age had a named GP in line with the new GP regulations. The practice offered proactive, personalised care to meet the needs of the older people registered with the practice and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**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. 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, health visitors and school nurses. Children were always seen as were pregnant women.

**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

# Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. Access to alcohol screening, smoking cessation and support with weight management was promoted to enable patients to make healthy lifestyle choices.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those patients with a learning disability. Annual health checks were undertaken for this patient group and longer appointments were made available.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked effectively with community health services, for example, health visitors and school nurses.

**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). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice worked to increase awareness about mental health and reduce stigma amongst local communities.

# Summary of findings

## What people who use the service say

We received 39 CQC patient comment cards and spoke with seven patients who were members of the practice patient participation group.

We spoke with people from different age groups and patients from different population groups, including, people who worked, parents, carers and people with long term conditions. The patients we spoke with were highly complementary about the service. Patients told us that they were treated with respect.

Patients we spoke with told us they were fully involved in deciding the best course of treatment for them and they fully understood the care and treatment options that had been provided.

Patients told us that staff were always pleasant and helpful.

Patients told us waiting areas and treatment rooms were clean and maintained.

Patients had confidence in the staff and the GPs who cared for and treated them.

We looked at feedback from the GP national survey for 2013/2014. 440 surveys were sent out and 53 returned, this is a 12% completion rate.

Feedback included; 47% of respondents would recommend this surgery to someone new to the area, in comparison to the local Clinical Commissioning Group (CCG) average of 75%.

Data from the survey showed that 96% of respondents had confidence and trust in the last GP they saw or spoke to, in comparison to the local (CCG) average of 95%.

And 97% of respondents had confidence and trust in the last nurse they saw or spoke to in comparison with the local (CCG) average of 98%.

And 56% of respondents with a preferred GP usually got to see or speak to that GP in comparison with the local (CCG) average of 58%.

63.7% 63.7% of patients are satisfied with the practice opening hours.

52.1% 52.1%% of patients reported it was easy to get through to the practice on the phone.

49.6% 49.6% of patients are satisfied with their experience of making an appointment.

61.2% 61.2%% of patients felt that their overall experience was good or very good.

## Areas for improvement

**Action the service SHOULD take to improve**

The provider should:

- A programme of more frequent clinical audits should be developed to demonstrate positive outcomes for patients.
- Pre-employment checks should be in place before staff are employed.
- A training record of all staff employed or contracted to work sessionally at the practice should be kept, for example, nurses, GPs and locum GPs.

## Outstanding practice

- The practice worked closely with the local community to promote health awareness. They worked closely with local community groups to ensure healthcare information reached groups of patients from black and minority ethnic communities. The GP worked closely with the local mosque and regularly spoke at information sessions to groups of the community on topics such as diabetes, forced marriage and domestic violence.
- The practice was committed to health promotion and prevention with a strong emphasis on improving

patient's well-being and lifestyle. The GP was working with Public Health England on providing dietary advice for patients who followed an Asian diet and the implications this might have for people's diabetes condition They also presented a weekly programme on Sky television to Pakistan and to the local Pakistani community in Oldham.

# Jarvis Medical Practice - GPCC

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

## Background to Jarvis Medical Practice - GPCC

Jarvis Medical Centre is located in Oldham, within the Oldham Clinical Commissioning Group (CCG.) The practice was responsible for providing treatment to approximately 3900 patients.

The practice team comprises one male lead GP, one male long-term locum GP, one female long-term locum GP and one female sessional GP. A practice nurse, a healthcare assistant, a practice manager, a part time deputy practice manager and four secretary/receptionist staff.

The practice was located within a CCG managed building alongside two other GP practices and a number of community services. The CCG had responsibility for all maintenance contracts including legionella testing for all the practices and community services within the building, for example dental services and a district nursing service. All treatment rooms are located on the ground floor along with a patient reception area. Access to the building is suitable for patients who use a wheelchair and there is a disabled toilet which also provides baby changing facilities.

The practice is open Monday to Friday, 9:30am – 1pm and 4pm – 6pm everyday with the exception of Wednesday when the practice closes at 2pm, for GP appointment. Nurse clinics are held Tuesday to Thursday from 8:30am-1pm and 2pm-5pm. Antenatal clinics were held each Monday between 9am -1pm and baby clinics were held twice weekly

All appointments are pre-bookable along with slots available for on-line booking and emergency/urgent appointments. All urgent appointment are seen on the day, with patients under the age of 5 years being given priority. Pregnant women are always seen.

The practice offers telephone consultations all day Monday to Friday and home visits are available for patients who are not well enough or physically able to attend the practice in person.

Patients can make appointments by telephoning, on line booking or by calling in at the surgery.

The practice has a GMS contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

When the practice is closed patients are directed to the out of hour's service provided by Go-To-Doc out-of-hours service.

The practice is currently not banded due to it being registered as a new GP practice on 19 December 2014. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice

has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

## Why we carried out this inspection

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

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

## How we carried out this inspection

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

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

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

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

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 4 March 2015. During our visit we spoke with a range of staff that included, GPs, practice manager, practice nurse and reception staff and spoke with patients who used the service. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We reviewed CQC patient comment cards where patients shared their views and experiences of the service.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, patient registration forms were not being fully completed as part of the patient registration process.

The staff we spoke had a clear understanding of when and how to raise safeguarding concerns and of their duty and responsibility to share concern with partner agencies, including local social services department and the police.

We reviewed safety records, incident reports and minutes of meetings, which demonstrated that the practice had systems in place that showed a consistent approach to reviewing safety.

A daily team brief took place over lunch time with all staff members to review how the practice was running and to respond to any identified issues or concerns.

Monthly practice meeting were held, as were monthly clinical meetings between the GP and the practice nurse to look at incidents and respond to patient care needs.

The practice worked closely with Oldham Clinical Commissioning Group and attended 'Cluster Meetings.' These meetings provided an opportunity for shared learning and discussion of significant events with other practices in the Oldham area.

Regular medication meetings were held with pharmacist advisors from the local clinical commissioning group (CCG) to ensure safe medication practice was followed and patient safety was upheld.

There were strategies in place, for example, in respect of patients that were frequent attendances A&E. This included making contact with patients to identify possible risk factors, reasons for attendance and what measures and or actions could be put in place to support and change patient behaviour.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, patients with long term health conditions and patients with poor mental health. Patients in these groups were closely monitored, and supported through joint multi-disciplinary working arrangements with other health and social care professionals.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed three significant event reports. These included an analysis of the incident, actions taken and a lessons learnt. Significant events were discussed at practice meeting; clinical meetings and periodically specific incidents were shared at CCG cluster meetings, which provided an opportunity for peer review. There was evidence that the practice had learned from significant events and findings were shared with relevant clinical and non-clinical staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

From the review of compliant investigation information, we saw that the practice ensured complainants were given feedback in response to their concerns and given an apology and informed of any actions taken.

National patient safety alerts were disseminated by email to practice staff.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the majority of staff had completed relevant role specific training on safeguarding, practice staff had completed training in safeguarding children and adult protection and the lead GP was trained to level three.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The practice followed Oldham Council safeguarding policy and protocol.

Good

# Are services safe?

The lead GP was the safeguarding lead for the practice. Staff told us they would approach the lead or any other GP in their absence if they had concerns about a patient. The lead was knowledgeable about the contribution the practice made to multi-disciplinary child protection work. Arrangements were in place to share safeguarding concerns with NHS and local authority partners and this ensured a timely response to concerns identified.

Multidisciplinary team meetings took place each month and were attended by district nursing staff, health visitors and school nurses. These meetings provided an opportunity to discuss and share safeguarding concerns and other information.

Within the patient record system there was an alert system which alerted GPs, nursing staff and reception staff to any ongoing child protection concerns and which also indicated that specific patients were to be seen only be the lead GP. Systems were also in place to monitor children or vulnerable adult's attendance at Accident and Emergency or missed appointments.

The practice had a chaperone policy and this was displayed in the patient waiting area and in all treatment areas. (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). Both the nurse and the healthcare assistant had completed chaperone training as had a number of reception staff. There were plans for all staff to complete this training so as to assist GP clinics. Patients we spoke with were aware of this service but none had direct experience of it.

**Medicines management**

Systems were in place for the management of medicines including medicines management policies. The lead GP took responsibility for medicines management at the practice and worked with pharmacy support from the Clinical Commissioning Group (CCG) who visited the practice quarterly to review prescribing trends, for example, for antibiotics and Benzodiazepines.

Emergency medicines for cardiac arrest were available within the building and were stored securely in the reception area. We checked the emergency drug box and saw that medicines were in date. We found the building had a defibrillator available to all practices and access to oxygen for use in emergency.

We saw other medicines stored within the practice were in date and systems were in place to check expiry dates. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. There was a clear cold chain protocol in place that followed NHS England's Protocol for Ordering, Storing and Handling Vaccines March 2014.

All repeat prescriptions were reviewed on a regular basis and only undertaken by clinicians and any changes were recorded in the patient's electronic records. We were made aware of an incident when changes to a patients medication had not been recorded in their notes and they had not received the correct prescribed medication. The incident was investigated fully by the practice and measures were put in place around the practice of issuing and responding to requests for repeat prescriptions.

The practice had guidelines in place for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 24 to 48 hours. Patients we spoke with told us that requests for repeat prescriptions were dealt with in a timely way.

Patient medication recall systems were firmly embedded within the practice and this included annual medicine review with a GP and the deputy practice manager telephoned all patients who requested a repeat prescription to check of the patient still required all medication listed. Patients we spoke with confirmed they had attended the practice for medicine reviews with a GP.

We saw prescriptions for collection were stored behind the reception desk. At the end of the day uncollected prescriptions were locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Patients were asked to confirm their name and address when collecting prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient.

**Cleanliness and infection control**

Good

# Are services safe?

Patients we spoke with told us the practice was 'always clean and tidy'. We saw that the practice was clean throughout and appropriately maintained and an infection control audit was last carried out in May 2014.

Cleaners were employed by a building management team who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis this was not held by the practice. Alcohol gel dispensers were sited at the entrance to the building and it was the responsibility of the building management team to replenish these. We found that one such dispenser was empty and needed to be replenished. We brought this to the attention of the practice manager, who agreed to speak with the building management team about replenishing it.

We saw there was hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Protective equipment such as gloves, aprons and masks were readily available. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin secured to the wall.

At the time of our inspection fabric privacy curtains were in use in all treatment areas. We were told that these were to be replaced from the 7 March 2015.

The practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

The lead GP at the practice had overall responsibility for infection control. We found the practice had a system in place for managing and reducing the potential for infection. An Infection Control Policy in place, along with protocols for the safe storage and handling of specimens.

We looked at staff training records and saw that the majority of staff had completed training in infection control. Newly appointed staff completed infection control training as part of their induction.

**Equipment**

The practice was located within a CCG managed building alongside two other GP practices and a number of community services. The CCG had responsibility for all maintenance contracts including legionella testing for the building and fire evacuation drills.

The practice had contracts in place for annual checks of fire extinguishers and portable appliance testing, all of which were routinely tested and displayed stickers indicating the last testing date.

The majority of staff had received training in fire safety and there was a nominated fire marshal for the practice. There was information in the reception and patient waiting area to advise patients what action to take in the event of a fire.

A defibrillator and oxygen were available for use in a medical emergency. These were stored in the reception area and were in reach in the event of a medical emergency.

There were contracts in place for annual checks of portable appliance testing and calibration of equipment such as spirometers, used to help people breath. Checks were undertaken and records kept to evidence that equipment was maintained.

Panic buttons were located in clinical and treatment rooms for staff to call for assistance in the event of a difficult situation and there was an alert facility with the electronic patient record system which staff could use to raise an alert if they were in a difficult situation.

**Staffing and recruitment**

The practice had a recruitment and selection policy which stated that a number of pre-employment checks would be taken up prior to employment, these included references and Disclosure and Barring Service (DBS) checks. However we found that the policy and procedure was not routinely followed. We looked at five staff recruitment records and found that not all checks were in place prior to employment. For example, one clinical member of staff had been in post four months before a DBS check was taken up. We discussed this with the practice who assured us the member of staff had not worked alone with patients and had shadowed other staff during this period. We looked at the records for another clinical member of staff who had been in post since January 2015, they too worked alone with patients and a DBS check had not been taken up prior to their employment. We were made aware that this staff members DBS check arrived the day after our inspection visit. The practice was advised that for all future staff employed all pre-employment checks must be in place prior to employment.

Good

# Are services safe?

For non-clinical staff that did not require a DBS check, the practice manager under took a risk assessment to support the decision not to apply for such a check.

We noted that verbal references for locum GPs were taken up as opposed to written references. We told the practice that they should satisfy themselves that all pre-employment checks were in place or had been taken up by the supplying agency as part of the practices recruitment process.

As part of the quality assurance and clinical governance processes checks of the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists were made to ensure that doctors and nurses continued to be able to practice.

Safe staffing levels were maintained. Collectively four GPs provided a service to patients. There were four receptionists, a practice nurse, a healthcare assistant, a deputy practice manger and a practice manager. Collectively the staff team were able to meet the needs of the patient population who were registered at the practice.

The practice manager and lead GP oversaw the rota for clinicians and this ensured that sufficient staff were on duty to deal with expected demand including home visits and daily patient demand for appointments including emergencies.

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. This ensured adequate staffing levels were maintained at all times and this included that 'ad-hoc' use of locums for holiday periods. The practice used a small bank of locum GPs whose work they were familiar with.

**Monitoring safety and responding to risk**

The majority of staff were trained in fire safety, basic life support and infection control and it was planned that new staff would complete this training imminently. We did not see training records for locum GPs and advised the practice manager that this information should also be collated and made available on future inspections.

Staff knew where the emergency equipment was stored and how to access this in the event of an emergency.

The practice had a system in place for reporting, recording and monitoring significant events.

The practice management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness.

A review of practice minutes confirmed that safety and risk was monitored and discussed at meetings and measures were in place to discuss who had been admitted to hospital as an emergency. This meeting also provided an opportunity for peer review and to discuss patients with complex care needs.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings, for example, safeguarding concerns and sharing information in a timely way with other agencies.

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

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. A business continuity plan was in place to deal with a range of emergencies that might impact on the day to day operation of the practice, for example, power failure, reduced staffing and access to the building.

The Practice has a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

Records showed that the majority of staff had received training in basic life support and there were plans for other staff to complete this training imminently. 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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

# Are services safe?

Patients were aware of how to contact the out of hours GP service and the practice website provided updated information for patients on this facility.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice provided a service for all age groups including older people, people with learning disabilities, children and families, people with mental health needs and to the working population. We found GPs, nurses and other clinical staff were familiar with the needs of each patient group and the impact of local socio-economic factors on patient care.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE).

GPs and other clinical staff case managed and monitored patients with long-term health needs. The practice held clinical meetings where all patients on the palliative care register were discussed.

The practice nurse and health care assistant provided and managed range of clinics, for example, asthma clinics, diabetes clinics, chronic obstructive pulmonary disease (COPD) reviews and new patient assessments. The practice held a register of patients who had a learning disability and these patients were called for annual health checks.

Patients with long term conditions were supported to self-manage, for example, diabetes. The practice was committed to health promotion and improving patient's life style.

Patients we spoke told us they were satisfied with the care and treatment they received. They told us they were included and had been consulted about treatment options.

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

We saw evidence of clinical audits that had been completed in respect of the practice. We looked at two audits that had been completed by medical students under the supervision of the practice GP. One included an audit of treatment for vitamin D deficiency and another for the use of ACE inhibitors, ACE inhibitors are medicines that are used mainly in the treatment of high blood pressure (hypertension) and heart failure. They are also used in some people with diabetes, for some forms of kidney disease, and after a heart attack, to help protect the heart.. We did not see evidence of other clinical audits.

The practice proactively contacted patients to remind them of annual reviews and those who had missed annual reviews. A patient recall system was in place for patients with chronic health conditions that included patients who received treatment for asthma and COPD.

Patients told us that GPs discussed and explained the potential side effects of medication during consultations.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

**Effective staffing**

The practice manager kept a record of training completed by the lead GP, practice nurse, health care assistant and non-clinical staff. Locum GPs were not included in this information so it was unclear if all staff at the practice had completed training, for example, in infection control.

Staff had access to training, the majority of which was completed through e-learning. Staff told us they were able to access training and received updates when required. We saw staff had completed mandatory training in safeguarding children and adults, health and safety, infection control, equality and diversity, basic life support, confidentiality, fire safety and some staff had completed training in the Mental Capacity Act.

We saw evidence that the practice nurse and non-clinical staff had an annual appraisal in the last 12 months. There were good informal support arrangements in place, which included a daily lunchtime meeting where all staff met to catch up and discuss how the day was going. Staff told us that the lead GP and the practice manager were supportive and approachable.

All GPs took part in yearly appraisal that identified learning needs from which action plans were documented. All of the GPs in the practice complied with the appraisal process. GPs are required to be appraised annually and every five

Good

# Are services effective?

## (for example, treatment is effective)

years undertake a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

All the patients we spoke with were complimentary about the staff. We observed staff to be competent, comfortable and knowledgeable about the role they undertook.

**Working with colleagues and other services**

The practice worked with other agencies and professionals to provide continuity of care for patients and ensured care plans were in place for the most vulnerable patients. Multi-disciplinary meetings took place each month to discuss patients with complex care needs, including end of life care and child protection concerns. The GP, nurse and practice manager communicated on a daily basis with community midwives, health visitors and district nurses who were located in the same building.

For patients requiring support with alcohol or substance misuse the practice referred to the community drug and alcohol team.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services, both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

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

The practice worked closely with Oldham Clinical Commissioning Group (CCG) and worked collaboratively on a number of local initiatives, including the management of diabetes.

The practice worked closely with local community groups to ensure healthcare information reached groups of patients from black and minority ethnic communities. The GP worked closely with the local mosque and regularly spoke at information sessions to groups of the community on topics such as diabetes and domestic violence.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice.

**Information sharing**

The practice had systems to provide staff with the information. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Electronic systems were also in place for making referrals through the Choose and Book system. (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 also had the option of using local services through a 'local triage' service. This meant that patients could attend local hospitals and other venues to see specialists.

Information received from other agencies, for example accident and emergency or hospital outpatient departments was read and actioned by GPs on the same day. Information was scanned onto electronic patient records in a timely manner. Systems were in place for managing blood results and recording information from outpatient's appointments.

All staff were required to sign a confidentiality agreement as part of their terms and conditions of employment at the practice. Staff fully understood the importance of keeping patient information in confidence and the implications for patient care if confidentiality was breached.

**Consent to care and treatment**

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. It was the practice that patients' verbal consent was recorded on their patient record for routine examinations.

GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act

Good

# Are services effective?

## (for example, treatment is effective)

2005 were adhered to. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they considered this in their practice and treatment of patients.

There was a practice policy for obtaining and documenting consent for specific interventions. It was the practice that for the majority of treatments patients gave implied or informed consent and arrangements were in place for parents to sign consent forms for certain treatments in respect of their children, for example, child immunisation and vaccination programmes. Where patients were under 16 years of age clinicians considered Gillick guidance. (This used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted.

Staff and patients had access to interpreter translation services on site, five days per week. The service was provided by Pennine Care NHS Trust. When patients attended the practice they were asked if they needed a translator to assist during their appointment. Staff told us the service was hugely popular and well used. There were plans to find an interpreter who could assist with Romanian patients. In addition to this the lead GP, locum GPs, nurse and health care assistant spoke Punjabi, Urdu, Pinjabi, Farsi, Sindhi and Patwari. Collectively these services ensured that where language might be a barrier to understanding treatment and thus obtaining consent patients were fully supported to make the right decisions that suited them.

**Health promotion and prevention**

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. All new patients were offered an initial health check with the practice nurse when a new patient assessment was completed; this included a review of the patient's lifestyle including family medical history and a review of their smoking and alcohol activity. The GP was informed of all health concerns detected and a follow up appointment was arranged.

The practice was committed to health promotion and prevention with a strong emphasis on improving patient's well-being and lifestyle. The lead GP held regular health presentations at a local mosque, subjects covered included, diabetes and dietary advice. The GP was working with Public Health England on providing dietary advice for patients who followed an Asian diet and the implications this might have for people's diabetes condition.

The GP held a 'diabetes check' event at a local park festival in June 2014 in an attempt to promote the awareness and dangers of diabetes. The event was said to be successful with a significant number of people taking advantage of the test.

The lead GP was currently engaged with the CCG and Public Health England on an outreach program to target local taxi companies to raise public awareness of diabetes.

The lead GP presented a weekly programme on Sky television to Pakistan in Urdu language. We were told that the GP had received questions from viewers in remote regions of Pakistan regarding diabetes, vitamin D and other health related questions. The local Pakistani community also accessed this programme.

Patients who smoked or who required assistance with weight management were provided with information about health trainers and smoking cessation clinics that operated within the building. These services were available to patients who were registered with one of three GPs in the building.

The practice also supported patients to manage their health and well-being. This included national screening programmes, vaccination programmes and long term condition reviews.

The practice also provided patients with information about other health and social care services such as carers' support.

Where it had been identified that patients who needed additional support, the practice was pro-active in offering additional help, for example, diabetes support. Practice nurses ran a number of chronic diseases clinics including Chronic Obstructive Pulmonary Disease (COPD) and diabetes clinics.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and there was a clear policy for following up non-attenders.

Good

# Are services effective?

## (for example, treatment is effective)

The practice kept a register of all patients with a learning disability and patients were offered an annual physical health check.

Written information was available for patients in the waiting area, on health related issues, local services and health promotion and carer's information.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed staff speaking with patients respectfully throughout the time we spent at the practice. We observed reception staff speaking to patients in a respectful way and we heard staff during telephone discussions also speaking in a courteous manner.

We spoke with seven patients and reviewed 39 CQC comment cards received as part of our inspection. Feedback from patients was positive about the level of respect they received and dignity offered during consultations. Patients we spoke with told us they had enough time to discuss things fully with the GP and patients told us GPs listened to them. Patients told us they were fully involved in decisions made about any treatments recommended.

Facilities were available within the surgery and upon request for patients who wanted to speak in private. It was normal practice that telephone calls would be transferred to the back office if more personal patient information was required.

We looked at a sample of consultation rooms, treatment rooms and clinical areas, all areas had privacy curtains to maintain patient dignity and privacy whilst they were undergoing examination or treatment.

The practice offered patients a chaperone service. Information about having a chaperone was in the waiting area. Staff we spoke with were knowledgeable about the role of the chaperone and only clinical staff undertook this role.

The patient electronic recording system included flags on patient records to alert staff to patient needs that might require particular sensitivity such as longer appointments at the end of the day or appointments within a specific time period due to mental health needs or learning disabilities.

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

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. They told us they felt listened to and time was taken to assist them to understand what was happening to them, they also said they were offered options to help them deal with their diagnosis.

Patients understood their care including the arrangements in respect of referrals to secondary care appointments at local and other hospitals and clinics.

Patients told us they usually got to see the same GP and they like this because if provided continuity of care.

Staff were knowledgeable about how to ensure patients were involved in making decisions. Care plan meetings were held monthly where GP, nursing staff and the practice manager reviewed the number of patients who had a care plan and those that were due for review.

We noted where required, patients were provided with extended appointments to ensure GPs and nurses had the time to help patients be involved in decisions.

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

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs were aware of local carer support groups that could be beneficial to carers registered with the practice.

We were told that when a family suffered bereavement, they would allow a period of mourning to pass in line with cultural belief, afterwich the GP would contact the family to offer support and signpost people to relevant advocacy services.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team.

Good

# Are services caring?

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

We saw evidence of service planning and the provision of appropriate services for different groups of patients. The GP had a good understanding of their patient population and responded appropriately to patient need.

The practice offered a range of specific clinics through the GP and nurse appointment system, including diabetes reviews and COPD, (**chronic obstructive pulmonary disease)** reviews. Patients told us that their health needs were met whilst attending GP consultations and or nurse consultations.

The practice was proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments and sourcing translation services for the newest patient group.

The surgery operated an electronic prescribing service. This enabled prescribers to send prescriptions electronically to a local pharmacy of a patient's choice.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and there were no concerns regarding the practice.

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

The practice worked with patients and families and in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

Longer appointments could be made for patients such as those with long term conditions, learning disabilities, mental health needs or who were carers.

**Tackling inequity and promoting equality**

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. Patients' electronic records contained alerts for staff regarding, for example, patients requiring additional assistance in order to ensure the length of the appointment was appropriate.

The practice provided home visits for those patients who were too ill or frail to attend in person. GPs provided telephone consultations and extended appointments were made available for any patient who required additional time.

We saw that the building was suitable for people who used a wheelchair. Disabled toilet facilities were shared with baby changing facilities. The entrance to the practice had level floor access and was suitable for wheelchair users.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

A car park was located to the side of the building and this was shared with patients who attended other GP services and clinics held in the building.

The practice provided equality and diversity training through e-learning.

The practice had a population of 97% Pakistan speaking patients. Interpreter services were provided by a local NHS trust and several clinical staff spoke Punjabi and Urdu. The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check.

**Access to the service**

Patients could access appointments by telephone, calling into the surgery and on line via the practice website. Patients were able to make appointments in advance. On the day emergency appointments were available by telephoning the practice. Where all appointments were filled, reception staff would take patients details which would be followed up by the GP and where required same day appointments or telephone consultations would be arranged. Pregnant women and sick children were always seen. Longer appointments were also available for patients who needed them and those with long-term conditions. The practice supported seven patients who lived in local nursing homes and we were told care plans were in place for these patients. Visits to patients in care homes was on a needs basis. The lead GP told us there were plans to recruit another locum to provide extra sessions for patients.

Information was available on the practice website that told patients about appointments, how to book appoints, including home visits and how to contact services out of hours. If patients called the practice when it was closed, an answerphone message gave information about out-of-hours services available.

From the CQC comment cards completed and speaking with patients we were told appointments were usually on time with not too much waiting. GP appointments were provided in 10 minute slots the majority of patients told us that it was relatively easy to get an appointment, though working patients told us it could be difficult trying to telephone the surgery early morning as the telephone line was busy and they could be on hold for up to twenty minutes.

Patients told us they were satisfied with the appointments system. They told us care was good and that the lead GP visited older people in their homes. Patients told us they usually got to see the same GP and they liked this.

Patients told us that the practice was very good at contacting them with blood and other test results. Sometimes the lead GP would telephone patient and discuss results and in between appointments the GP would telephone patients to check on their progress. Patients were particularly complimentary about the lead GP who they felt offered a very personalised service.

Patients told us all GPs, the practice nurse and the health care assistant explained proposed treatment to them and they felt fully involved in their care.

We received 39 CQC comment cards from patients. All cards provided positive feedback on the service patients had received. One respondent told us the care was good, their children were always seen but that it could take time to get through on the telephone.

**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. The practice manager was the designated responsible person who handled complaints in the practice. The practice manager was mindful to respond and deal with patient's complaints as they arose in an attempt to avoid complaints escalating.

Information about the complaints process was provided in the patient practice leaflet and on the website. Though we did not see any complaints information on display in the practice.

Patients we spoke with told us they knew how to make a complaint. They told us they felt comfortable about making a complaint and they were confident their complaint would be dealt with fairly. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw complaints were logged and investigated by the practice manager who consulted with GPs and or nursing staff where relevant. Investigations addressed the original issues raised and action was taken to rectify problems. We saw that the provider responded to complaints' in a timely manner and had taken action to resolve their complaints.

# 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 clear vision to deliver quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's beliefs and statement of purpose. Staff we spoke with knew that the practice was committed to providing good quality primary care services for all patients, including the management of long term health conditions.

We saw evidence that demonstrated the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

There was an established leadership structure which was led by the GP who took responsibility for most of the daily running of the practice.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hard copy. We looked at a sample of policies and saw these reflected up to date guidance and legislation.

There was a clear leadership structure and the lead GP took responsibility for medicines management, infection control and safeguarding across the practice. Staff we spoke with were clear about their roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had systems to identify, assess and manage risks related to the service including health and safety issues. Systems were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. These included monthly practice meeting and weekly clinical meetings.

It was evident that staff were able to raise concerns in a constructive manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff.

There was limited evidence of the use of clinical audits and how this was used to plan for patient care.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to monitor services and record performance against the quality and outcomes framework.

**Leadership, openness and transparency**

We observed that leadership was clearly visible across the practice and with well-established lines of accountability and responsibility.

The staff group was a stable one. Staff told us they enjoyed their work and they felt supported and there was good team work across the practice.

Staff told us they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

Information sharing arrangements were good and each member of staff's contribution was valued. Staff told us they would feel comfortable speaking with the registered provider or the practice manager should they have any concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, which were in place to support staff.

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

The practice had recently formed a patient participation group (PPG) that had its first meeting in February 2015. Thirteen patients attended the meeting, including representatives from various population groups; retired people, parents, working people and older people. The group was looking for ways to get younger people and students involved.

The practice worked closely with its local community.

We met seven members of the group who told us the overall aims of the group were to support patients, improve outcomes for patients and to challenge the practice on behalf of patients.

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints.

# Are services well-led?

Good

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

We saw that there was a complaints procedure in place, with details available for patients in the practice leaflet and on the website.

Lunch time meetings were held daily and provided staff with an opportunity to feedback on how the delivery of the service was going for that day, including what had worked well and if there had been any problems.

When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged and this provided staff with an opportunity to provide feedback.

**Management lead through learning and improvement**

The provider had systems in place to review incidents referred to as 'significant events analysis' (SEA).

Quality assurance arrangements at the service ensured that performance was reviewed regularly.

These included periodical reviews of clinical performance data provided by the local clinical commissioning group.

Other audits included a monthly drug stock take, a review of NHS health checks and of the corresponding patient groups who had attended.

NHS patient safety alerts, for example, medicine alerts, were shared with staff.

Annual appraisal and supervision arrangements were well developed and established across all staff groups.

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at four staff files and saw that training had been recorded and appraisals had taken place. Staff told us that the practice was very supportive of training and continuing professional development.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GPs were involved in the local clinical meetings and one GP led on medicine management for the CCG.

Similarly the practice nurse regularly attended their professional forum groups established by the CCG to provide training and support and share good practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.