Droylsden Medical Practice

Quality Report

1-3 Albion Drive
Droylsden
Manchester
M43 7NP
Tel: 0161 3427777
Website: www.gtdhealthcare.co.uk/practice/droylsden-medical-practice

Date of inspection visit: 21 April 2015
Date of publication: 11/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Droylsden Medical Practice was inspected on 21 April 2015. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. Overall we rated the practice as good and specifically in respect of being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

The practice has a system in place for reporting, recording and monitoring significant events. Significant incidents and events are used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice.

The practice has systems in place to ensure best practice is followed. This is to ensure that people's care, treatment and support achieves good outcomes and is based on the best available evidence.

Information we received from patients reflected that practice staff interact with them in a positive and empathetic way. They told us that they were treated with respect, in a polite manner and as an individual. Patients expressed their satisfaction in respect of the quality of the care and treatment provided at the practice. However patients consistently expressed concern in respect about difficulties in getting through to the practice on the telephone in the mornings and securing an appointment to see a clinician. The provider had reviewed these issues and taken action to address them.

However there were areas of practice where the provider should make improvements.

Importantly the provider should:

Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these relating to 2 week referrals and prescribing. Both were quite recent and consequently there was no evidence of re-audit. However it was evident there were plans in place for this to be done. The documentation relating to the reasons for the audit and the summary action plan was sparse and lacking in detail. The provider should ensure the documentation relating to clinical audits is improved.

Summary of findings

Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good formal clinical and practice meetings had been infrequent until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained.

A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response. When a new diagnosis has been made this was coded (read coding system) in the summary of patient's medical records. However we were informed that there was a considerable backlog in completing this coding (and new summaries). To ensure the summary in patient's medical records are as contemporaneous as possible this backlog should be addressed as soon as possible.

At the time of our visit the two regular GPs were seeing the more complex cases, managing all medication reviews and repeat prescriptions and the clinical administrative work generally. We were informed the regular GPs were providing 43 hours per week in GP time and locums 32 hours per week. The potential risk of this balance on the role of the regular GPs should be regularly reviewed by the provider to ensure the requirements on the salaried GPs remain manageable.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data demonstrated patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. 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 well with multidisciplinary teams.

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 what services were 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 NHS England and Tameside and Glossop Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. However patients consistently expressed concern in respect about difficulties in getting through to the practice on the telephone in the mornings and securing an appointment to see a clinician. The provider had acknowledged these concerns and following consultation with patients had and was continuing to take action to address these issues. The practice had good facilities and

Summary of findings

was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

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 responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. However although day to day networks of peer support and communication between individual staff and the wider multidisciplinary team were good, formal clinical and practice meetings had been infrequent for some time until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions and regular performance reviews.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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 patients with complex needs the clinicians 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. 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.

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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients 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 had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 40 completed CQC comment cards and spoke with ten patients on the day of inspection and six members of the practice's patient participation group (PPG) prior to or during our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and those who completed CQC comment cards commented positively about the care and treatment they received from the doctors and nurses and the support provided by other members of the practice team. They said that their privacy and dignity was maintained and that they were treated with respect. However patients consistently expressed concern in respect about difficulties in getting through to the practice on the telephone in the mornings and securing an appointment to see a clinician.

We also looked at the results of the January 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

What this practice does best;

83% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. (Local CCG average: 80%).

87% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. (Local CCG average: 85%).

86% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. (Local CCG average: 85%).

What this practice could do to improve

26% of respondents with a preferred GP usually get to see or speak to that GP. (Local CCG average: 59%).

49% of respondents would recommend this surgery to someone new to the area. (Local CCG average: 75%).

49% of respondents described their experience of making an appointment as good. (Local CCG average: 72%).

394 surveys sent out. 124 surveys back. 31% return rate.

Areas for improvement

Action the service SHOULD take to improve

Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these relating to 2 week referrals and prescribing. Both were quite recent and consequently there was no evidence of re-audit. However it was evident there were plans in place for this to be done. The documentation relating to the reasons for the audit and the summary action plan was sparse and lacking in detail. The provider should ensure the documentation relating to clinical audits is improved.

Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good formal clinical and practice meetings had been infrequent for until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained.

A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response. When a new diagnosis has been made this was coded (read coding system) in the summary of patient's medical records. However we were informed that there was a considerable backlog in completing this coding (and new summaries). To ensure the summary in patient's medical records are as contemporaneous as possible this backlog should be addressed as soon as possible.

At the time of our visit the two regular GPs were seeing the more complex cases, managing all medication reviews and repeat prescriptions and the clinical

administrative work generally. We were informed the regular GPs were providing 43 hours per week in GP time and locums 32 hours per week. The potential risk of this balance on the role of the regular GPs should be regularly reviewed by the provider to ensure the requirements on the salaried GPs remain manageable.

Droylsden Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC inspector, a GP specialist advisor and a practice manager specialist advisor. Our inspection team also included an expert by experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive

Background to Droylsden Medical Practice

Droylsden Medical Practice is situated just outside the centre of Droylsden. At the time of this inspection we were informed 3,300 patients were registered with the practice.

The practice population experiences higher levels of income deprivation than the practice average across England. There is a lower proportion of patients above 65 years of age (9%) than the practice average across England (16.7%). The practice has a higher proportion of patients under 18 years of age (18.3%) than the practice average across England (14.8%). 39 per cent of the practice's patients have a longstanding medical condition compared to the practice average across England of 54%.

At the time of our inspection two salaried GPs and locum GPs were providing primary medical services to patients registered at the practice. The GPs are supported in providing clinical services by a a practice nurse and a health care assistant Clinical staff are supported by the practice manager and the other staff in the practice team.

The practice contracts with NHS England to provide Alternative Provider Medical Services (APMS) to the patients registered with the practice.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by the registered provider (Go To Doc). The practice website provides patients with details of how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

Why we carried out this inspection

We inspected this service as part of our new 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?

Detailed findings

- 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 21 April 2015. We reviewed all areas that the practice operated, including the administrative areas. We received 40 completed CQC comment cards and spoke with ten patients on the day of inspection and five members of the practice's patient participation group (PPG) prior to or during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We also spoke with four representatives of the provider's management team, two GPs, the practice nurse, the practice manager and one of the reception staff.

Good

Are services safe?

Our findings

Safe Track Record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and NHS Tameside and Glossop Clinical Commissioning Group (CCG)) to share what they knew. No concerns were raised about the safe track record of the practice. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. Learning was based on a thorough analysis and investigation of things that go wrong. All staff were encouraged to participate in learning and to improve safety as much as possible. Opportunities to learn from external safety events were identified. We spoke with clinical and non-clinical staff. They told us that the culture at the practice was open and fair and they were actively encouraged to report incidents and mistakes and said that they were supported when they did so. We looked at records relating to how the practice team learnt from incidents and subsequently improved safety standards. Clear documented guidance regarding reporting and managing significant events was provided to staff. The documented examples we looked at showed how incidents were investigated by defining the issue clearly and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again. Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good, formal clinical and practice meetings had been infrequent for some time until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained.

The practice had a system for managing safety alerts (from external agencies). These were communicated to the GPs and other relevant staff and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults were in place. We discussed how safeguarding was managed at the practice and looked at the systems used to ensure safeguarding issues were managed. All the staff we spoke with demonstrated knowledge and a clear understanding of their role in respect of safeguarding children and vulnerable adults.

The electronic patient records system alerted the GPs and other clinical staff when a safeguarding issue or safeguarding plan had been identified and developed for children and vulnerable adult patients. We also saw that the practice team were communicating and meeting regularly with the safeguarding leads for children and adults at social services and the CCG when required and provided reports to them when requested to do so. Staff training records clearly demonstrated when clinical and non-clinical staff had last been provided with regularly updated safeguarding training in respect of children and vulnerable adults. We saw evidence that the GPs had received updated enhanced (level 3) children's safeguarding training. The practice nurse was the nominated lead for safeguarding at the practice and was supported by the safeguarding lead in the provider's senior management team.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. No issues in respect of chaperoning were raised by patients we spoke with or received information from. A Disclosure and Barring Service (DBS) check had been conducted for all staff performing chaperone duties to assess the person's suitability to work with potentially vulnerable people.

Medicines Management

Systems were in place for the management, secure storage of prescriptions and medicines within the practice. Management of medicines was the responsibility of the clinical staff at the practice. A system was in place to ensure the security of prescription forms against theft and misuse. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed

regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions. It was established practice to regularly review and monitor the effects of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicines reviews and repeat prescribing was the responsibility of the two salaries GPs at the practice and was not carried out by the locum GPs. These were being managed appropriately at the time of our visit but can be quite time consuming tasks in terms of managing the volume of medicine review/ repeat prescription requests for the two regular GPs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained.

Cleanliness & Infection Control

Systems were in place to ensure the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing infection prevention and control. The practice nurse provided leadership in this area and had been provided with training to fulfil this role. Other staff had been provided with regular infection prevention and control training and this included the use of appropriate hand washing techniques. We saw appropriate hand washing facilities (including the provision of liquid soap and disposable towels) and instructions were available throughout the practice. We saw evidence that recent checks had been undertaken to make sure measures taken to prevent the spread of potential infections were periodically risk assessed. This is important to ensure their continued effectiveness and minimise the risks associated with potential infections for patients, staff and visitors to the practice. Water taps were regularly flushed and water temperatures checked to minimise the risk from legionella. Legionella is a germ found in the environment which can contaminate water systems in buildings.

We saw practice staff were provided with suitable protective equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients.

We looked at the three consulting/treatment rooms. These rooms were clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place.

Arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste was stored safely and securely in specially designated bags before being removed by a specialist contractor. We saw records that detailed when such waste was removed.

Equipment

A record of maintenance of clinical, emergency and other equipment was in place and it was recorded when any items were repaired or replaced. We saw that all of the equipment had been regularly tested and the practice had systems in place for personal appliance tests (PAT) to be completed and for the routine servicing and calibration of equipment.

Staffing & Recruitment

The practice was staffed to enable the primary medical service needs of patients to be met. A system was in place to plan surgery times that ensured a GP was available for all the sessions. We looked at staff recruitment practices and records. A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body, for example The General Medical Council (GMC). Also a Disclosure and Barring Service (DBS) check had been conducted for all staff to assess the person's suitability to work with potentially vulnerable people.

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all clinical practice staff received regularly updated basic life support training. We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

A fire safety risk assessment was in place and records showed fire safety checks had been conducted regularly. All staff had received regularly updated fire safety training.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

We looked at records that demonstrated the practice had carried out risk assessments to identify risks associated with their premises and that they were managing these risks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We looked at minutes of recent (January to March 2015) practice meetings where new guidelines were shared, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we looked at confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good formal clinical and practice meetings had been infrequent until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained.

Discussion with the two salaried GPs and the practice nurse and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these relating to two week referrals and prescribing. Both were quite recent and consequently there was no evidence of re-audit. However it was evident there were plans in place for this to be done. The documentation relating to the reasons for the audit and the summary action plan was sparse and lacking in detail. The provider should ensure the documentation relating to clinical audits is improved. There was a clear commitment by the clinicians to participating in clinical audit and we saw evidence of several in their early stages including one related to glaucoma.

We saw evidence of individual peer review and support to discuss issues and potential improvements in respect of clinical care. The recent practice meeting minutes (January to March 2015) we looked at provided details of how the actions to make improvements taken were monitored over time to ensure they were embedded and effective. However such meetings, as detailed above have only been re-introduced and need to be sustained.

Feedback from patients we spoke with, or who provided written comments, was very positive and complimentary in respect of the quality of the care, treatment and support provided by the practice team. There was no evidence of discrimination of any sort in relation to the provision of care, treatment or support.

Effective staffing

The practice team comprised of clinical and non-clinical staff. We were informed by the provider that there were difficulties in recruiting permanent GPs. To manage this locum GPs were employed to ensure there were sufficient GP access for the patient population. The practice sought the engage the services of regular locums. At the time of our visit the two salaried GPs were seeing the more complex cases, managing all medication reviews and repeat prescriptions and the clinical administrative work generally. We were informed the regular GPs were providing 43 hours per week in GP time and locums 32 hours per week. The potential risk of this balance on the role of the regular GPs should be regularly reviewed by the provider to ensure the requirements on the regular GPs remain manageable.

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. We saw that annual staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff we spoke with said they were supported to access relevant training that enabled them to confidently and effectively fulfil their role.

Good

Are services effective?

(for example, treatment is effective)

GPs were supported to obtain the evidence and information required for their professional revalidation. This is when doctors demonstrated to their regulatory body, the General Medical Council (GMC), that they are up to date and fit to practice. The practice nurse was supported to attend updates to training that enabled them to maintain and develop their professional skills.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included patients who had complex needs or had been diagnosed with long term condition. There were clear mechanisms to make such referrals promptly and this ensured patients received effective, co-ordinated and integrated care. We saw referrals were assessed as being urgent or routine. Patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice.

We saw clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good, formal clinical and practice meetings had been infrequent for some time until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hour's service. In particular the practice provided detailed clinical information to the out of hour's service about patients with complex healthcare needs.

All patient contacts with the out of hour's provider were reviewed by a GP the next working day. The practice had established and developed links with the integrated care programme in the local area. This was particularly helpful for elderly patients and those with complex health conditions who were at higher risk of being admitted to hospital.

A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response. When a new diagnosis has been made this was coded (read coding system) in the summary of patient's medical records. However we were informed that there was a considerable backlog in completing this coding (and new summaries). We note that this issue had been significantly contributed to by an influx of approximately 500 hundred new patients over a three month period in 2014 (following the closure of a local GP practice). To ensure the summary in patient's medical records is a contemporaneous as possible this backlog should be addressed as soon as possible. This is to ensure all clinicians are aware of any new diagnosis and that summaries sent to other services (such as the out of hours service) contains the new diagnosis.

Information sharing

All the information needed to plan and deliver care and treatment was stored securely (electronically) but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples of this when looking at how information was shared with social services and the CCG safeguarding teams.

Consent to care and treatment

Patients we spoke with told us they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said they were provided with enough information to make a choice and gave informed consent to treatment. The January 2015 GP patient survey reflected that 83% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 86% said the last GP they saw or spoke to was good at explaining tests and treatments and 71% said the last nurse they saw or spoke to was good at explaining tests and treatments.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Where people lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with

Good

Are services effective?

(for example, treatment is effective)

legislation. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and of supporting those who did not have the mental capacity to make a decision in relation to their care and treatment.

Clinical staff spoken with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

All new patients, including children, were provided with appointments to establish their medical history and current health status. This enabled the practice clinicians to quickly identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma.

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health. A wide range of health promotion information was available and accessible to patients particularly in the patient waiting area of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation and influenza vaccinations were provided.

The provision of health promotion advice was also an integral part of each consultation between clinician and patient. Patients were also enabled to access appropriate health assessments and checks. A system was in place to provide health assessments and regular health checks for patients when abnormalities or long term health conditions are identified. This included sending appointments for patients to attend reviews on a regular basis. When patients did not attend this was followed up to determine the reason and provide an alternative appointment.

Patients with long term sickness were provided with fitness to work advice to aid their recovery and help them return to work.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 40 completed CQC comment cards and spoke with ten patients on the day of inspection and six members of the practice's patient participation group (PPG) prior to or during our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Comments we received from patients and those who were close to them were very positive about the way in which practice staff treated people. Patients told us the practice staff communicated with them well. They also told us staff at the practice treated them with respect, in a polite manner and as an individual. The January 2015 GP patient survey reflected that 87% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. 71% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. 96% of respondents had confidence and trust in the last GP they saw or spoke to. 92% of respondents had confidence and trust in the last nurse they saw or spoke to.

We observed staff to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation rooms. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided.

Staff we spoke with said if they witnessed any discriminatory behaviour or where a patient's privacy and dignity was not respected they would be confident to raise the issue with the practice manager. We saw no barriers to patients accessing care and treatment at the practice.

Care planning and involvement in decisions about care and treatment

Comments we received from patients demonstrated that practice staff listened to them and concerns about their health were taken seriously and acted upon. They also told us they were treated as individuals and provided with information in a way they could understand and this helped them make informed decisions and choices about their care and treatment. A wide range of information about various medical conditions was accessible to patients from the practice clinicians and was prominently displayed in the waiting area.

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment, the practice had taken action to address this. For example language interpreters were accessible if required.

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact patient care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers. The practice waiting room contained prominently displayed information about carers and patients are invited to self-refer to the practice with regard to their caring responsibilities. A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated care and treatment to ensure that patient's needs were appropriately met. One of the salaried GPs regularly attends the CCG locality forum and subsequently updates colleagues at the practice via email.

Efforts were made to ensure patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Patients were able to access appointments with a male or female GP if preferred. Longer appointments could be made for patients such as those with long term conditions or who were carers. Home visits were provided by the GPs to patients whose illness or disability meant they could not attend an appointment at the practice

Systems were in place to ensure that vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening. Where patients did not attend such appointments there was a system in place to establish the reasons why and offer another flexible appointment to encourage patients to attend and discuss any concerns they may have.

We saw the practice carried out regular checks on how it was responding to patients' medical needs. This activity analysis was shared with Tameside and Glossop CCG and formed a part of the Quality and Outcomes Framework monitoring (QOF). It also assisted the practice to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews. Documented information we looked at demonstrated that QOF delivery at the practice had considerably improved over the last 12 months.

Systems were in place to identify when people's needs were not being met and informed how services at the practice were developed and planned. A variety of information was used to achieve this. For example profiles of the local prevalence of particular diseases, the level of social deprivation and the age distribution of the population provided key information in planning services. Significant events analysis, individual complaints, survey results and clinical audits were also used to identify when patients needs were not being met. This information was then used to inform how services were planned and developed at the practice.

A longstanding issue with the use of benzodiazepines had been identified in the population generally. To help manage this at the practice a substance misuse worker held a clinic every two weeks.

The practice had a reception area, a patient waiting area and three consultation and treatment rooms. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were also facilities to support the administrative needs of the practice.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to individual needs and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. People in vulnerable circumstances were able to register with the practice.

The practice had achieved the 'Pride in Practice Gold Award' (in February 2015) to celebrate their dedication to delivering an excellent service to all patients. Pride in Practice is a quality assurance support service provided by the Lesbian & Gay Foundation to GP practices to support improvements in health outcomes for their lesbian, gay and bisexual (LGB) patients, as well as strengthen their engagement with, and understanding of LGB people.

Access to the service

We received 40 completed CQC comment cards and spoke with ten patients on the day of inspection and six members

Good

Are services responsive to people's needs?

(for example, to feedback?)

of the practice's patient participation group (PPG) prior to or during our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with or received comments from patients consistently expressed concern in respect about difficulties in getting through to the practice on the telephone in the mornings and securing an appointment to see a clinician. These issues were also reflected in the responses to the most recent survey conducted by the provider and the 2015 GP survey.

The results of the January 2015 GP survey reflected 66% of respondents were are satisfied with the surgery's opening hours. 62% of the respondents found it easy to get through to the practice by phone. 61% were able to get an appointment to see or speak to someone the last time they tried and 88% said the last GP they saw or spoke to was good at giving them enough time. 77% of respondents found the receptionists at the practice helpful. Also 92% said the last appointment they got was convenient and 49% described their experience of making an appointment as good. 49% said they would recommend this surgery to someone new to the area. (We were informed by the provider that since 1 January 2015 77% of patients completing the Friends and Family Test stated they would recommend the practice to their friends and family).

We discussed access issues with the provider and looked at what actions had been taken to address them. The provider acknowledged the issues and told us they had been exacerbated by an influx of approximately five hundred new patients over a three month period in 2014 (following the closure of a local GP practice) and difficulties in GP recruitment. In response the provider had developed an action plan to improve patient access. This included introducing changes to the appointment system from the beginning of May 2015, the introduction of on-line booking over the coming months for routine appointments and recruiting a GP to fill the currently vacant post. We saw that the provider had produced a newsletter to inform patients of the issues identified by the survey's and detail what action they have taken to improve access. To keep patients updated the newsletter was to be produced on a quarterly basis.

The opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas and were also contained on the practice website and in the practice information leaflet readily available to patients in the reception area. The practice provided extended hours appointments on Monday and Thursday evenings (up to 8pm) and alternate Saturday mornings (10am to 1pm) for patients who are unable to access appointments at other times. The practice opened at 8am Monday to Friday.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information about the out of hours service was provided to patients.

GP consultations were provided in 15 minute appointments. Where patients required longer appointments these could be booked by prior arrangement. A system was in place for patients who required urgent appointments to be seen the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at 12 formal complaints received in the last 12 months. In line with good practice all complaints or concerns were recorded and investigated. The complaints record detailed the nature of the complaint, the outcome of the investigation and how this was communicated to the person making the complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

There was a leadership structure with an allocation of responsibilities amongst the GPs and the practice team. However due to the current everyday pressures the emphasis had been appropriately prioritised on providing good clinical services. This limited the time the salaried GPs were able to provide proactive clinical leadership. The provider and practice management team described to us a value system which provided the foundations for ensuring the delivery of a high quality service to patients. The practice did have plans for the future however we noted the provider was awaiting the outcome of a review of their existing contract with NHS England. The culture at the practice was one that was open and fair. Discussions with GPs, other members of the practice team and members of the practice's patient participation group (PPG) demonstrated this perception of the practice was shared.

Governance arrangements

There were defined lines of responsibility and accountability for clinical and non-clinical staff. Whilst networks of peer support and communication between individual staff and the wider multidisciplinary team were good formal clinical and practice meetings had been infrequent until January 2015. These meetings provide important opportunities for all practice staff to come together to share and discuss ideas, improve practice and learn as a team from incidents. The provider should ensure the action they have taken to hold such meetings on a monthly basis is sustained.

Discussion with GPs and other members of the practice team demonstrated the practice operated an open and fair culture that enabled staff to challenge existing practices and thereby make improvement to the services provided. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve the quality of the services provided. One of the salaried GPs regularly attends the CCG locality forum and was very aware and knowledgeable about local health care trends and developments and shared this with the practice team in order to enable them to consider what improvements could be made to develop and improve the services they provided to patients.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. Documented information we looked at demonstrated that QOF delivery at the practice had considerably improved over the last 12 months.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these relating to two week referrals and prescribing. Both were quite recent and consequently there was no evidence of re-audit. However it was evident there were plans in place for this to be done. The documentation relating to the reasons for the audit and the summary action plan was sparse and lacking in detail. The provider should ensure the documentation relating to clinical audits is improved. There was a clear commitment by the clinicians to participate in clinical auditing and we saw evidence of several in their early stages including one related to glaucoma.

Leadership, openness and transparency

The service was transparent, collaborative and open about their performance. There was a leadership structure. However due to the current everyday pressures the emphasis had been appropriately prioritised on providing good clinical services. This limited the time the salaried GPs were able to provide proactive clinical leadership. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at recently re-introduced practice meetings or during the regular informal discussions that took place.

Measures were in place to maintain staff safety and wellbeing. Induction and on going training included safety topics such as the prevention of the spread of potential infections and other health and safety issues. A procedure for chaperoning patients was also in place to protect staff as well as patients.

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

Are services well-led?

Good

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the January 2015 GP patient survey and the last survey conducted by the practice in. Both surveys reflected high levels of satisfaction with the care and treatment provided at the practice. However patients consistently expressed concern in respect about difficulties in getting through to the practice on the telephone in the mornings and securing an appointment to see a clinician. The provider had recognised the importance of addressing these issues and had developed an action plan to make improvements and monitor the effectiveness of the actions taken. Patients were being encouraged to actively comment on the services available and developments within the practice.

The practice had a patient participation group. We spoke with five members of the group prior to our visit. They told us that when issues were identified they were consulted to develop plans to address them. They felt their views and contributions were respected and valued.

The practice had gathered feedback from staff through formal practice meetings (re-introduced in January 2105), appraisals and informal discussions. Staff told us they were able to give feedback and discuss any concerns or issues and that their contributions were respected and valued.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through regular training and appraisal. We saw that staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

GPs were supported to obtain the evidence and information required for their appraisals and 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 practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff to ensure outcomes for patients improved.