

# Dr Ninan and Partners

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected Dr Ninan and Partners on 19 November 2014 as part of our new comprehensive inspection programme.

We reviewed information provided to us leading up to the inspection and spent nine hours at the main surgery and branch surgery, speaking to nine members of staff, six patients and reviewed 42 comment cards which patients had completed leading up to the inspection. From all the evidence gathered during the inspection process we have rated the practice as good.

During our inspection the comments from patients were positive about the care and treatment they received.

Feedback included individual praise of staff for their care and kindness and going the extra mile.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

- Majority of patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day.
- Staff understand their responsibilities to raise concerns, and report incidents.
- The practice is clean and well maintained.
- There are a range of qualified staff to meet patients' needs and keep them safe.
- The practice works with other health and social care providers to achieve the best outcomes for patients.

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

Importantly, the provider must:

The practice did not follow current guidance when prescribing hypnotic medicines and did not have systems in place to appropriately prescribe and use hypnotic medication.

In addition the provider should:

# Summary of findings

- The practice did not have policy and procedures in place for staff to ensure they take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005.
- 57.8% of patients experiencing poor mental health had a care plan in place, however this was 28.1% below the national average.

**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?

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Leading up to the inspection we noted from nationally available prescribing data that the practice was prescribing three times higher than the national average for hypnotic medication such as Benzodiazepines. We found no evidence of systems in place to address the issues of long term and repeat prescribing of Benzodiazepines.

Requires improvement



### Are services effective?

The practice is rated as good for effective. In the main National Institute for Health and Care Excellence (NICE) guidance is referenced and used. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Majority of staff have received training appropriate to their roles. The practice can identify appraisals and the personal development plans for staff. Multidisciplinary working was evidenced.

Good



### Are services caring?

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



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

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Good



# Summary of findings

patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

## Are services well-led?

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient representative group (PRG). Staff had received inductions, regular performance reviews and attended staff meetings.

**Good**



# 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

The practice is rated as good for the population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework, working as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

Good



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Patients had annual reviews to check their health and medication needs were being met. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were very responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Nursing staff were mindful of symptoms of post natal depression and discussed this with new mothers.

A midwife ran antenatal clinics weekly from the practice.

Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Good



# Summary of findings

Staff were knowledgeable about child protection and a GP took the lead with the Local authority and other professionals to safeguard children and families.

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

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation with referrals available to Health trainers. The practice had extended opening hour enabling people to make appointments outside normal working hours. Appointments could be booked online and up to four weeks in advance.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and voluntary sector 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 and out of hours.

Good



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

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems or a dementia diagnosis. The registers supported clinical staff to offer patients an annual appointment for a health check and a medication review.

For 94.6% of patients with dementia there care had been reviewed in a face-to-face review, 10.8% above the national average.

Only 57.8% of people experiencing poor mental health had a care plan in place. QOF data provided evidence the practice were below

Requires improvement



# Summary of findings

the CCG and national average when responding to the needs of people with poor mental health, such as, a record of alcohol consumption was 74.5 %, 17.9% below the CCG average and body mass index (BMI) only 68.2% of patients had this recorded in the preceding 12 months, 22.9% below the CCG average.

The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.



# Summary of findings

## What people who use the service say

During our inspection we spoke with six patients and three members of the patient representative group. We reviewed 42 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 79% of respondents would recommend this surgery to someone new to the area and 82% describe their overall experience of this surgery as good.

We saw the patient representative group, made up of five male and three female patients, conducted a survey with patients during 2013 in which 249 patients responded. We noted the following results: When asked 'If you need to see a Dr urgently did you get an appointment for the same day', 79% said yes and when asked 'thinking of when you consult your usual Dr, how do you rate, how well the Dr listens', 23% said excellent, 28% very good and 33% good.

## Areas for improvement

### Action the service **MUST** take to improve

The practice did not follow current guidance when prescribing hypnotic medicines and did not have systems in place to appropriately prescribe and use hypnotic medication.

### Action the service **SHOULD** take to improve

The practice did not have policy and procedures in place for staff to ensure they take appropriate action where people did not have the capacity to consent in line with the Mental Capacity Act 2005.

57.8% of patients experiencing poor mental health had a care plan in place, however this was 28.1% below the national average.

# Dr Ninan and Partners

## 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. Experts by Experience are members of the public who have direct experience of using services.

### Background to Dr Ninan and Partners

Dr Ninan and Partners provides primary medical services from two surgeries in Hindley, a district of Wigan from Monday to Friday. Hindley Health Centre is open five days a week between 8am and 8pm Mondays and Thursday, 9am to 6pm Tuesday and Friday and 9am to 5pm on Wednesdays. Hindley Green branch surgery is open five days a week between 9am and 5pm, Monday, Thursday and Friday. Tuesday's 9am to 6pm and Wednesdays 9am to 5pm.

The practice provides home visits for people who were not well enough to attend the centre.

The practice has four GP partners all male and a salaried female GP. The GPs are supported by two nurses and a health care assistant.

Dr Ninan and Partners is situated within the geographical area of NHS Wigan Borough Clinical Commissioning Group (CCG).

Dr Ninan and Partners is responsible for providing care to 7873 patients, of whom 50.6% are female, 49.4% male and 5.58% are from Black and minority ethnic populations.

When the practice is closed patients were directed to the out of hours service. 24-hour emergency cover is provided by Ashton, Leigh and Wigan Out-of-Hours Service.

### 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

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 19th November 2014. The inspection team spent nine hours at the practice, including a visit to the branch surgery. We reviewed information provided on the day by the practice, observed how patients were being cared for and reviewed a sample of anonymised patient records.

# Detailed findings

We spoke with six patients, nine members of staff and three members of the patient participation group. We spoke with a range of staff, including receptionists, the practice manager, three GPs and two practice nurses.

We reviewed 42 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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)

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The practice engaged with other GP practices to carry out peer reviews and took part in the local commissioning improvement schemes.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk and near misses. All staff we spoke with were aware of the procedure for reporting concerns and incidents. We reviewed significant event reports and saw that appropriate action had been taken and where changes to practice were required, this had been cascaded to staff during team meetings or sooner face to face communication where required.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice had systems in place to respond to safety alerts.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, through multi-disciplinary meetings with other health and social care professionals.

After reviewing the General Practice Outcome Standards 2013 data (The outcome standards represent the basic patients should expect to receive from general practice.) we saw the practice was approaching review by NHS England, due to having nine triggers highlighting that they were currently achieving below a nationally agreed or expected threshold. This included: Assessment of Depression Severity, Hypnotics prescribing, (the prescribing of minor tranquilliser such as Benzodiazepines) and providing

patients with smoking cessation advice. Speaking with the practice, they had no systems in place to address the issues associated with the prescribing of Benzodiazepines or assessment of depression severity, with no mental health lead in place.

### Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. The practice had in place arrangements for reporting significant incidents that occurred at the practice. We saw from the practice significant events log and speaking with staff, they had carried out detailed investigations and

provided detailed records of outcomes and actions taken in light of the significant events. Monthly staff meetings were in place, where significant events formed part of the agenda to discuss findings and plan action to be taken. All staff told us the practice was open and willing to learn when things went wrong. Staff told us learning from incidents was shared via team meetings and email.

### Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible. However there was some confusion as to who took a lead for adult safeguarding.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure, outlining action staff should take and contact details of the Local Authority Safeguarding team.

We saw procedures and child protection/adult protection flow charts were in place for staff to follow should they have concerns about a patient. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who had responsibility for safeguarding children; they had completed training to level three and were knowledgeable about the contribution the practice could make to safeguarding patients.

A chaperone policy was in place and we saw several notices alerting patients to the availability of a chaperone.

## Are services safe?

Speaking with staff who acted as chaperones, they were clear of the role and responsibility but non-clinical staff had not received training. We saw the practice manager had identified training and the staff who required chaperone training. Non-clinical staff told us when acting as a chaperone; they would stand outside of the dignity curtain. General Medical Council (GMC) Intimate examinations and chaperones (2013) guidance advises that chaperones should: 'stay for the whole examination and be able to see what the doctor is doing, if practicable.'

### Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations. The practice had in place Standard Operating Procedures for controlled drugs in line with good practice issues by the National Prescribing Centre.

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group (CCG).

GPs reviewed their prescribing practices as and when medication alerts were received. Staff told us information and changes to prescribing were communicated during meetings, or via email alerts. Staff told us they regularly discussed and shared latest guidance on changes to medication and prescribing practice. A member of the medicines management team from the CCG supported the practice on a weekly basis working closely with the medicines administrator and practice manager.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines including those used by the GP for home visits and found these were in date, stored safely and where required, were refrigerated. A record was kept whenever any medicines were used. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature.

We were shown the safety checks carried out in relation to prescriptions being issued. The practice maintained a

register to track prescriptions received and distributed. We noted whole prescription pads were issued to each GP for home visits, once these had been issued; no checks were in place to monitor the number of prescriptions used.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. At the end of the day we were told these 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, i.e. date of birth and address of patient to ensure the right patient received the correct medication.

Leading up to the inspection we noted from nationally available prescribing data the practice was prescribing three times higher than the national average (Practice value 0.96, National average 0.31) of hypnotic medication such as Benzodiazepines between October 2013 and June 2014. Risks associated with the long-term use of hypnotic drugs have been well recognised for many years. These include falls, accidents, cognitive impairment, dependence and withdrawal symptoms. The Medicines and Healthcare products Regulatory Agency (MHRA) reinforced the issues regarding addiction to benzodiazepines in the July 2011 edition of Drug Safety Update.

Speaking with three GPs we found no evidence of systems in place to address the issues of long term and repeat prescribing of Benzodiazepines. We were told they had a programme in place during 2012/13 and achieved a slight reduction, but this had not been maintained and no on-going plans were in place to change this prescribing practice.

The practice had alerted potential new patients who were currently being prescribed Benzodiazepines, they would be placed on a reduction plan, however there was no evidence of any patients being supported to reduce and ultimately stop taking Benzodiazepines.

### Cleanliness & Infection Control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed.

We saw up to date policies and procedures were in place, the policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines.

## Are services safe?

These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice. We saw from staff records all staff were up to date with training linked to infection control.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

A cleaning schedule was in place which gave detailed guidance to the cleaning staff.

We noted a colour coding scheme in place was in line with good practice guidelines to ensure cleaning materials and equipment were not used across all areas. This was to prevent the spread of infection.

The practice carried out routine infection control audits and checks, which included, hand hygiene; consultation and treatment room(s); prevention and management of needle stick and sharps injuries and specimen handling.

We looked in four consulting rooms. All the rooms had hand wash facilities and work surfaces which in the main were free of damage, within one nurse's room some of the edging was coming away from the worktop. A request had been submitted for these to be replaced enabling them to be cleaned thoroughly. We saw the dignity curtains had been routinely cleaned and replaced when required.

### Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment, this included the defibrillator and oxygen.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

All the rooms had a panic alert system for staff to call for assistance.

### Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for

employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records for five staff. We saw recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that checks had been carried out with the disclosure and barring service (DBS) for all staff where required.

### Monitoring Safety & Responding to Risk

The nurses and health care assistants had been allocated lead roles to make sure best practice guidance was followed in connection with infection control, learning disabilities and smoking cessation.

Speaking with the practice manager and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Action was taken to respond to and minimise risks associated with patient care and premises. We saw evidence that staff received regular cardiopulmonary resuscitation (CPR) training and training associated with the use of the defibrillator and the treatment of anaplasia.

### 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. The business continuity plan was under review following major changes to the branch site to ensure appropriate up to date arrangements were in place.

We saw fire safety checks were carried out and full fire drills were scheduled. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in

## Are services safe?

dealing with medical emergencies including cardiopulmonary resuscitation (CPR). We noted guidance from the Resuscitation Council was displayed and easily accessible to staff should it be required in an emergency.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Staff completed assessments of patients' needs and these were reviewed when appropriate. We saw within the ten patient records reviewed by our GP assessments had taken place in the majority of cases, however it was not clear that all reviews had taken place as alerts remained on the patients records, these included medication reviews. We spoke with the practice manager who told us there were some out of date alerts since changes had been made to the system, but that reviews had been carried out.

Looking at the records of two patients with poor mental health we saw care plans were not in place in line with best practice and GPs were not following National Institute for Health and Care Excellence (NICE) when prescribing and repeat prescribing of Benzodiazepines. Tests had been requested and referrals made within time frames recommended by NICE.

Speaking with the practice nurses they explained to us how they reviewed patients with chronic diseases such as asthma on an annual basis, and were able to make direct referrals to specialist services where required.

We saw from the National Quality Outcome Framework (QOF), all patients with atrial fibrillation had received appropriate tests and treatment, as had patients with Asthma. Majority of patients (89.9%) with diabetes had received appropriate tests and treatment, slightly below the CCG average.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks. All patients with learning disabilities had access to annual reviews using the nationally recognised template.

The GPs carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF showed only 57.8% of patients with poor mental health had care plans in place 28.1% below the national average.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment, ensuring where necessary young people were able to give informed consent without parents' consent if they are under 16 years of age.

Staff were able to describe how they assessed patients capacity to consent in line with the Mental Capacity Act 2005. We noted some staff had received training in relation to mental capacity.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers.

We were told for patients where English was their second language an interpreter could be arranged over the phone. This was in line with good practice to ensure people were able to understand treatment options available.

### Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition such as diabetes. A range of patient information was available for staff to give out to patients which helped them understand conditions and treatments. For all patients newly diagnosed with diabetes they provided with a 45 minute appointment with a nurse, who would provide advice and guidance.

The nursing team had taken the lead on auditing all patients who had been diagnosed with chronic kidney disease (CKD) or were at risk of CKD, from this they recalled all patients where appropriate to ensure they were being provided with the correct treatment and on appropriate management plans. As a result the nursing team told us patient's kidney function and quality of life had improved.

The practice held monthly governance meetings and full staff meetings up to four times a year.

The practice used the information they collected from the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting majority of



# Are services effective?

(for example, treatment is effective)

patients well with long term health conditions such as, asthma, chronic kidney disease and heart failure. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 100% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

## Effective staffing

The staff group at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs, nurses and assistant practitioner.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes 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.

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice.

New staff including GP registrars participated in an induction programme. We saw an induction checklist was in place to ensure all areas were covered.

The practice had a system for supervision and appraisal in place for all staff.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw staff had access to training as part of their professional development with nurses attending training in which

updates on key issues was provided. One nurse had been supported to undertake degree level training on chronic obstructive pulmonary disease (COPD) and was in the process of completing a respiratory degree.

## Working with colleagues and other services

We found the GPs and nurses at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. The practice held multi-disciplinary team meetings to ensure information was shared effectively.

The practice worked with health visitors, district nurses and a podiatrist provided appointments at the surgery.

The nurses had links with the learning disabilities community team and were able to access support and guidance where required to meet the needs of patients.

## Information Sharing

The GPs described how the practice provided the 'out of hours' service with information to support, for example end of life care. Information received from other agencies, for example accident and emergency or hospital outpatient departments was read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice had in place a system to ensure information was shared with appropriate agencies for patients at the end of life such as out of hours providers, ambulance service and district nurses.

For the most vulnerable patients, patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

## Consent to care and treatment

A policy and protocol was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16s and consent for immunisations. A consent form was in place for staff to complete and included details of where a parent or guardian signed on behalf of a child.

The policy did not include guidance for staff on how to take appropriate action where people did not have the capacity

# Are services effective?

(for example, treatment is effective)

to consent in line with the Mental Capacity Act 2005. However all clinical staff we spoke with understood the principles of gaining consent including issues relating to capacity. Staff told us where they had concerns about a patient's capacity they would refer patients to the GP.

GPs and nurses were able to outline a mental capacity assessment they would use to support them in making assessments of a patient's capacity and outlined the need to keep clear records where decisions were made in the best interest of patients who did not have capacity to make decisions. This showed us that staff were following the principles of the Mental Capacity Act and making detailed records of decisions to ensure patients or relatives were involved in the decision making process.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care.

For patients where English was their second language, an interpreter could be arranged over the phone. This is in line with good practice to ensure people are able to understand treatment options available and give voluntary and informed consent.

## Health Promotion & Prevention

New patients looking to register with the practice were able to find details on the practice website or by asking at reception. New patients were provided with an appointment with a member of the nursing team for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of a patient's annual reviews and health checks.

The nurses provided lifestyle advice to patients. This included dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. Patients who wanted support to stop smoking could be referred to an in-house smoking cessation service provided by the health care assistant.

A health trainer provided appointments for patients at the practice.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough) Primary. We saw from QOF that 100% of child development checks were offered at intervals that are consistent with national guidelines and policy.

Flu vaccinations for children and adults were in progress, with clinics being run on a Saturday and supported by the patient representative group (PRG) with a good uptake. For housebound patients home visits were available to ensure they had access to seasonal flu vaccinations. Shingles vaccination clinics were available for patients of the appropriate age.

Information for carers was available in the waiting area and was publicised and promoted by the patient representative group (PRG) during events such as flu vaccination sessions. Information was also available on the practice website.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with six patients and three members of the patient participation group. We reviewed 42 CQC comment cards. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared.

We saw all phone calls from and to patients were carried out in a private area behind reception and not at reception; we were told this helped to maintain patient confidentiality.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms. We also noted a sign at reception asking patients to stand back to allow other patients confidentiality at reception.

We were aware from the results of the GP Patient Survey 2013 and representatives of the PRG, confidentiality at reception was cause for concern. The practice were addressing this by reviewing seating arrangements and had redesigned the reception area at the branch site as part of the refurbishment.

The majority of the patients we spoke with were complimentary about the reception staff and this was also reflected in the GP Patient Survey where 86% said the receptionists at this practice were helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity.

We found all rooms were lockable and had dignity screens in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

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

The majority of the patients told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP but they had to wait for appointments. Results of the GP national patient survey showed 71% with a preferred GP usually get to see or speak to that GP.

Majority of patients we spoke with told us the GP and nurses were patient, listened and took time to explain their condition and treatment options. This was reflective of the results from the GP national patient Survey in which 78% said the last GP they saw or spoke to was good at listening to them; however only 65% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care.

A nurse took a lead on supporting patients with a learning disability, we saw for patients with learning disabilities care plans were in place. Care plans were also in place for 80% of patients at high risk of unplanned hospital admissions, however speaking with staff and reviewing data from The Quality and Outcomes framework QOF data for 2013/14 only 57.8% of patients with poor mental health had care plans in place.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005. However there was no policy and procedures in place for staff to support staff in this decision making process.

Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions. Where required independent translators were available by phone for patients where English was their second language.

We noted where required patients were provided with extended appointments up to 45 minutes for reviews with patients with learning disabilities to ensure they had the time to help patients be involved in decisions.

## Are services caring?

In reception we saw a notice board specifically for carers, where there were notices to guide patients to support and advice.

### **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.

From the GP national patient survey 74% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern and 90% had confidence and trust in the last GP they saw or spoke to.

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. Following recent training provided by a hospice changes had been made to improve the way in which Do Not Attempt Resuscitation DNACPR was approached with patients and relatives. We were told bereavement support for patients was provided by the hospice.

Where required patients could be referred to counselling services.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

The practice was proactive in working with patients and families, 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.

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.

We saw where patients required referrals to another service these took place in a timely manner. This included referrals to health trainers.

A repeat prescription service was available to patients, via the website, 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 had a Patient Representative Group (PRG) made up of five male and three female patients. The PRG meet on a regular basis to review the findings from surveys and to discuss ways in which patient experience could be improved. The PRG had suggestion boxes in the waiting area for patients to make suggestions on areas they would like the PRG to look at on their behalf; these were reviewed at PRG meetings and with the practice manager as and when required. We spoke with three members of the PRG, they told us the practice was proactive at sorting things out and listening to their views.

### Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different languages if required.

The practice had recognised different patients' needs when planning services with GPs taking the lead in areas such as palliative care.

The practice was on one level with access for people with disabilities, or pushchairs and specific parking spaces for patients with a disability. A disabled toilet was available as were baby changing facilities.

The practice ensured that for patients where English was their second language they had easy access to an interpretation service. The practice had in place information in different languages, accessed via the website, information on the website was also available in spoken word. These interpretation services ensured patients were able to make informed decisions about care and treatment.

The practice provided extended appointments where necessary and appointments were available 9am to 8pm Mondays and Thursday enabling people to make appointments out of normal working hours.

### Access to the service

Patients were able to make appointments up to four weeks in advance by telephone or online via the practice website. For same day or emergency appointment patients were required to phone the practice on the day. We were told by reception staff any children or vulnerable patients would get a same day appointment.

Results from the survey carried out by the PRG in 2013, 79% of patients reported if they needed to see a GP urgently they got an appointment for the same day. The GP national survey reported 83% were able to get an appointment to see or speak to someone the last time they tried and 97% say the last appointment they got was convenient.

Home visits were available for patients each day by telephoning the practice before 10am.

Patients were clearly guided to out of hours service with information provided on the website and an answerphone should patients call the practice out of hours.

The GPs provide extra appointments during the winter months to manage the increased demand.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

## Are services responsive to people's needs? (for example, to feedback?)

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

Complaints information was displayed in the waiting area and available on the website. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

The practice had a system in place to investigate concerns, with meetings held to discuss issues

arising from complaints and incidents. We reviewed the log of serious incidents and concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning cascaded to staff.

We noted a suggestion box located in the waiting area for patients to provide on-going feedback, these were monitored and responded to by the practice manager.

# Are services well-led?

Good 

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

## Our findings

### Vision and Strategy

The practice had a statement of purpose in which they outlined their aims and objectives, these included, to provide a high quality standard of care for all groups and To help reduce unnecessary secondary care admission.

Observing staff and speaking with staff and patients we found the practice clearly demonstrated a commitment to compassion, dignity, respect and equality.

We spoke with nine members of staff and they all expressed their understanding of the core values; however we saw in some areas such as medicine management the latest guidance and best practice were not being followed to deliver care and treatment.

The practice manager told us within the next twelve months they had plans in place to roll out the 'Friends and Family' test, employ another nurse to help provide extra care for the elderly and continue to be actively involved in the Quality, Innovation, Productivity and Prevention (QIPP)

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

The practice held monthly governance meetings which looked at practice issues including complaints, significant incidents and audits. Full staff meetings were held up to four times a year.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing 89.4% in line with national standards, 6% below the CCG average.

The practice had a clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We were provided with a range of audits the practice had carried out over the past year, these included the use of diuretics (A diuretic medication that promotes the production of urine) within the patient population and an audit of chronic kidney disease (CKD).

The practice carried out significant events analysis (SEA). We reviewed five SEAs and saw analysis of the factors leading up to the event had been recorded. We saw from minutes of practice meeting SEAs were discussed.

The practice had arrangements in place for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months.

The practice worked alongside 24 other GP practices in the local area as part of a locality group, the practice manager told us how they and the clinical staff benefited from monthly forums, including a practice manager forum, nurse forum and GP forum for which one of the GPs took a lead for the locality.

### Leadership, openness and transparency

We were shown a leadership structure which had named members of staff in lead roles. The practice set out leadership and governance roles among the GP and nursing staff. For example one GP led on training and supporting GP registrars, another palliative care and another diabetes. Nurses took a lead for infection control. We saw the practice manager took the lead for the management of complaints and significant events.

We spoke with nine members of staff and they were all clear about their own 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 manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and induction policies, which were in place to support staff. Staff we spoke with knew where to find policies if required.

### Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through the GP national survey, PRG survey, compliments and complaints.

We saw that there was a complaints procedure in place and visible to patients in the waiting area and on the practice website. We noted there was a suggestion box for patients to leave on-going feedback.

# Are services well-led?

Good 

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

We reviewed complaints made to the practice over the past twelve months and found in the main they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 79% of respondents would recommend this surgery to someone new to the area and 82% describe their overall experience of this surgery as good.

We saw the results of the practice patient survey carried out by the PRG, We saw from the results, when asked 'thinking about when you have seen a particular Dr, how quickly were you seen?' 14% stated same day, 20% stated within 2 working days, 27% within 5 working days and 28% more than 5 days. Patients were also asked 'in reception can other patients hear what you say', 65% said yes.

We saw from minutes of meeting the results had been discussed with the PRG and practice staff. An action plan had been agreed which included, improve communication with patients, improve appointment access, privacy at reception/waiting area and Hindley Green (branch surgery) refurbishment. We saw the refurbishments had been completed to a high standard, this included pictures from the stroke association bought by the PRG.

We saw an invitation for patients to join the patient representative group (PRG) displayed in the waiting area and on the practice website.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff within the practice.

## **Management lead through learning & improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training. We saw from staff records training and continuing professional development had been recorded.

The practice were involved in a local Single Commissioning engagement and outcome scheme, which involved them participating in a two QIPP programmes. The practice engaged in a programme of peer review with other GPs in the locality, having prioritised three areas to focus during 2014/15 these included referrals to secondary care and quality of services.

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.

The practice was a GP training practice, with a GP registrar working within the practice. Dr Ninan and Partners is an accredited GP Training Practice by the North Western Deanery of Postgraduate Medical Education.



This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines  <b>The practice did not follow current guidance when prescribing hypnotic medicines and did not have systems in place to appropriately prescribe and use hypnotic medication.</b>