Urban Village Medical Practice

Quality Report

Ancoats Primary Care Centre
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Date of inspection visit: 23 June 2015
Date of publication: 20/08/2015

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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Urban Village Medical Practice on the 23 June 2015 as part of our comprehensive inspection programme.

From all the evidence gathered during the inspection process we have rated the practice as outstanding.

Specifically, we found the practice to be outstanding for providing safe, caring, responsive, effective and well led services. They were outstanding for providing services to most of the population groups, specifically those who were vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice and meet the needs of the most vulnerable of patients, particularly homeless patients.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided in ways to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Virtual Patient Participation Group (VPPG).
- The practice had good facilities and multi-skilled staff and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand

Summary of findings

- The practice had a clear vision which had equality, quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had provided primary care services to homeless people in Manchester for over 15 years, with over 700 homeless patients currently registered with the practice. The practice had developed a wide range of services for patients to improve their health outcomes including access to weekly multidisciplinary drop-in clinics. Additional to these in house primary and secondary care services the practice had also established The Manchester pathway (Mpath) a hospital in-reach service at Manchester Royal Infirmary (MRI).
- The practice ran a campaign during October 'Socktober' in which they encouraged donations of socks that they gave to the homeless who attend the practice.
- The practice had the largest substance misuse shared care service in place with Manchester drug and alcohol service 'RISE' with approximately 200 patients in treatment.
- The practice had flexibility within their appointment system to ensure all patients requiring on the day emergency appointments were seen.
- We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014/15 and the friends and family test. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 96% of respondents described their overall experience of this surgery as good and 98% said the last appointment they got was convenient
- The practice had achieved Gold, the highest award in the NHS 'Pride in Practice' award from the Lesbian, Gay, Bisexual and Transgender Foundation.

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?

Outstanding

The practice is rated as outstanding for providing safe services. This practice was safer than other similar practices in meeting the needs of the most vulnerable of patients and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff with a good skill mix to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with National Institute for Health and Care Excellence guidelines and embraced the 'Standards for commissioners and service providers' produced by the Faculty of Homeless Health in 2011 (revised 2013). They were actively working to meet all the standards for primary care services for homeless people. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for all patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. They provided a range of shared care services such as a substance misuse service and leg ulcer clinics. They were innovative and proactive in improving patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from patients, external partners and the virtual patient participation group (VPPG). The practice reviewed the needs of its local population and the homeless population they supported, taking business cases forward and engaging with NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment, and in non-emergency situations with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. The practice had a clear vision with equality, quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a virtual patient participation group (VPPG) and homeless patient participation group.

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

Outstanding ☆

The practice is rated as outstanding for the population group of older people. Nationally reported data showed the practice had better than average outcomes for conditions commonly found amongst older people. The practice had a register of all patients over the age of 75 and those patients had a named GP.

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 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. This meant they worked, 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. Speaking with a district nurse and the Manchester North Cancer lead for MacMillan they told us the whole practice embraced good quality end of life care and were proactive in ensuring patients and their relatives needs were regularly reviewed and needs met.

The practice was responsive to the needs of older people,. GPs, nurses and health care assistants provided home visits and rapid access appointments for those with enhanced needs. Clear alerts were placed on the appointment system highlighting vulnerable patients to ensure reception staff acted in a timely manner and allocated same day appointments or home visits. Staff routinely contact patients by telephone to remind them of appointments.

We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable, had care plans in place with a named care coordinator. Monthly multidisciplinary meetings were held to discuss care of these patients, and included neighbourhood teams such as district nurses, community matrons, social workers and respiratory teams.

The practice were proactive in immunisation campaigns such as influenza, shingles and pneumonia vaccinations and achieved 69% up take of seasonal flu vaccinations for patients over 65 years of age and 47% for carers.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Each chronic disease area had a clinical lead who kept the practice up to date with latest guidelines. Nursing staff had lead roles in chronic disease management with a practice nurse trained with an extended role in diabetes including insulin initiation.

Summary of findings

Patients at risk of hospital admission were identified as a priority. Care plans and named GPs were in place for those patients with complex, long term conditions. Patients who were on the unplanned admissions register were contacted following admissions to identify any changes to care and treatment required and reviews of care were discussed at practice meetings. The practice worked closely with neighbourhood teams such as district nurses, community matrons, social workers, and respiratory teams holding monthly multidisciplinary meetings to review patients' needs.

The practice had an electronic register of patients with long term conditions and a recall system in place to ensure patients were called for a review annually so their condition could be monitored and reviewed. For homeless patients with long term health conditions the practice worked as a team with the support of the homeless case managers and the networks they had established across the city to find people. This involved letters to hostels, the nurse attending day centres and outreach sessions to ensure wherever possible homeless patients had the same access to annual reviews as any other patients.

The practice monitored the needs of those patients with a cancer diagnosis and/or those on the palliative care register. A pathway was in place as part of the cancer improvement scheme to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held monthly with other health and social care providers.

The national Quality Outcome Framework (QOF) 2013/14 showed, that the majority of clinical and public health outcomes had been achieved to the same level or above the local CCG and national average. For example 100% of outcomes for patients with asthma and 95% of outcomes for patients with Chronic obstructive pulmonary disease (COPD) had been achieved.

Families, children and young people

Outstanding ☆

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 who were at risk.

Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We saw evidence to confirm this such as asthma plans in place for children, using the template developed by Asthma UK. Children were provided with two copies of the plan, one of which they were to take into school and pass to teachers assisting schools to support children in managing their asthma. 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.

We saw that staff dealing with young people under 16 years of age without a parent present were clear of their responsibilities to assess Gillick competency.

Sexual health, contraception advice and treatment were available to patients including young people. Enhanced family planning clinics were available to all residents of Manchester which included contraceptive implant and coil fitting.

We saw good examples of joint working with midwives, health visitors and school nurses. Weekly baby immunisation and child health surveillance clinics were held at the practice and community midwives ran the antenatal clinic. Non-attenders were discussed as part of weekly safeguarding meetings and followed up by practice nurses/GPs and where appropriate home visits arranged

Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. Dedicated safeguarding childrens clinicians' and administration leads were in place. Weekly safeguarding meetings took place with nurse leads and GP leads reviewing all children's out of hours contacts, A&E attendances and discharge summaries to detect early any safeguarding concerns. Where patients were suspected to be victims of domestic violence, this was recorded within patient records and staff were vigilant and made appropriate referrals where necessary. Staff were also aware of the needs to protect children from exploitation and provided examples of joint working to protect vulnerable young people.

Working age people (including those recently retired and students)

Good

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 such as appointment booking, prescription ordering, viewing medical records, and a full range of health promotion and screening which reflected the needs for this age group. The practice also had Facebook and Twitter pages in which they provided details of services and healthy lifestyle information.

Appointments and prescriptions could be booked online in advance. On the day emergency appointments were available as were home visits and telephone consultations to patients who could not attend the practice.

Summary of findings

New patient medical assessments and NHS health checks were offered to patients. These were used to gather detailed information from patients enabling the practice to offer timely interventions, treatment and education to prevent deterioration in patients' health and manage any long term conditions identified. Patients were able to access minor surgery at the practice with a specialist GP offering monthly clinics.

Patients were provided with a range of healthy lifestyle support including smoking cessation with referrals available to external agencies to support people in leading healthier lifestyles.

The practice achieved good uptake of flu vaccinations, 47% in line with national averages. The practice offered meningitis enhanced services to students, and encouraged uptake of chlamydia screening .

The practice had a system in place to identify carers, to enable them to provide appropriate support and referrals.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable.

The practice has provided primary care to homeless people in Manchester for over 15 years, with over 700 homeless patients currently registered with the practice. The practice have developed a wide range of services for patients to improve their health outcomes including access to weekly multidisciplinary drop-in clinics, drug workers, homeless case managers, leg ulcer clinics and infectious disease clinic to facilitate access to Hepatitis C and Blood borne virus treatment. Additional to these in house primary and secondary care services the practice had also established The Manchester pathway (Mpath) a hospital in-reach service at Manchester Royal infirmary (MRI) based on the work done by London Pathway who pioneered work in this field. Staff from the homeless team visited MRI, to assess homeless patients who were frequent attenders at Accident and Emergency (A&E) or current inpatients. They ensured that they were discharged with a package of care, housing, engagement with primary care services and so did not re-attend A&E unnecessarily. Initial evaluations of the mpath services showed 43% reduction in A&E attendance and 39 % reduction in hospital admission rates.

The practice had the largest substance misuse shared care service in place with Manchester drug and alcohol service 'RISE' with approximately 200 patients in treatment. There were two full time drug workers based at the practice. The GPs and practice nurse offered flexible and opportunistic appointments to support their

Summary of findings

work and provided holistic care packages, as well as opportunistic health screening to ensure those vulnerable patients had easy access to primary care alongside support from key workers. All patients were given access to a full range of drug services including counselling, substitute prescribing and detoxification services. All patients who received substitute prescribing undertook an initial health check which particularly focused on cardiovascular screening, the identification of chronic disease particularly COPD and full bloodborne virus testing. All patients in treatment received an annual health check as well as a six month general practitioner review in combination with their regular contact with their drugs worker.

The practice also offered a range of shared care provisions within the practice which included leg ulcer clinics and a fortnightly specialist led infectious disease clinic to facilitate access to Hepatitis C and bloodborne virus treatment.

The practice had a GP learning disabilities lead that focused on the patient as a whole looking at their physical, emotional and social needs. Patients were offered annual reviews and provided with written care plans.

For patients where English was their second language, or were hard of hearing the practice had close links with interpreter services and easy access to language line. The practice were also developing an email access system for patients with hearing difficulties.

All clinical rooms had a clear notice of adult safeguarding contacts and access to links/forms via an intranet. Adult safeguarding cases were regularly discussed at practice meetings in order to protect vulnerable patients. The practice regularly worked with multidisciplinary teams in the case management of vulnerable people.

We saw a well-established practice team who know the patients well and would actively seek to help a patient should there appear to be concern for their wellbeing.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding 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. The register supported clinical staff to offer patients an annual appointment for a health check and

a medicine review. Multidisciplinary meetings were held with community psychiatric nurses (CPNs) and local mental health services to meet the needs of those patients with poor mental health.

The practice also held a register of patients with dementia to enable regular reviews of care. The practice worked with multidisciplinary teams in the case management of people with dementia. The practice had in place care planning for patients with dementia where required for example where patients were at risk of unplanned hospital admissions. They actively screened patients who were displaying signs or at risk of dementia using a professionally recognised tool.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations and made referrals to mental health services via the Mental Health Gateway Service (Single point of access). Patients also had access to an onsite counselling service.

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 18 patients, who reflected the diversity of the patient population, including working age professionals, older people, parents, patients with learning disabilities and homeless patients. We reviewed 16 CQC comment cards which patients had completed leading up to the inspection.

The comments were all very positive about the care and treatment patients received from the whole team at UVMP from reception staff, nurses, GPs and the homeless team. Words used to describe the service included fabulous, wonderful, 'top notch', person-centred and excellent. Patients told us they felt they were listened to, 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 we were provided with numerous examples of where staff went the extra mile. We reviewed the results of the GP national survey carried out in 2014/15 and noted 96% described their overall experience of this surgery was good, higher than the local and national average and 94% would recommend this surgery to someone new to the area again higher than the local and national average.

Areas for improvement

Outstanding practice

- The practice had provided primary care services to homeless people in Manchester for over 15 years, with over 700 homeless patients currently registered with the practice. The practice had developed a wide range of services for patients to improve their health outcomes including access to weekly multidisciplinary drop-in clinics. Additional to these in house primary and secondary care services the practice had also established The Manchester pathway (Mpath) a hospital in-reach service at Manchester Royal Infirmary (MRI). Staff from the homeless team visited MRI, to assess homeless patients who were frequent attenders at Accident and Emergency (A&E) or current inpatients. They made sure they were discharged with a package of care, housing, engagement with primary care services and so did not re attend A&E unnecessarily.
- The practice ran a campaign during October 'Socktober' in which they encouraged donations of socks that they gave to the homeless who attend the practice, to help maintain healthy feet and support patients suffering from conditions such as trench foot.
- The practice had the largest substance misuse shared care service in place with Manchester drug and alcohol service 'RISE' with approximately 200 patients in treatment. There were two full time drug workers based at the practice. The GPs and practice nurse offered flexible and opportunistic appointments to support their work and provided holistic care packages, as well as opportunistic health screening to ensure those vulnerable patients had easy access to primary care alongside support from key workers.
- The practice had flexibility within their appointment system to ensure all patients requiring on the day emergency appointments were seen. They also varied the length of appointments and could demonstrate the impact of this by reduced use of the accident and emergency services and out of hour's providers.
- We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014/15 and the friends and family test. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 96% of respondents described their overall experience of this surgery as good and 98% said the last appointment they got was convenient

Summary of findings

- The practice had achieved Gold, the highest award in the NHS 'Pride in Practice' award from the Lesbian, Gay, Bisexual and Transgender Foundation, which demonstrated the practice's commitment and dedication to ensuring a fully inclusive patient-centred service.

Urban Village Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse, practice manager adviser and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Urban Village Medical Practice

Urban Village Medical Practice (UVMP) provides primary medical services in Ancoats, North Manchester for people living in Manchester city centre, Ancoats and the surround areas. The practice also provides specialist services to the homeless population within Manchester. The practice is open Monday to Friday, with appointments available between 8:30am and 6:00pm, with a multi-agency drop in service for homeless patients on a Wednesday afternoon.

The practice provides telephone consultations and home visits for people who are unable or not well enough to attend the centre.

The practice has three contracts in place for providing services. A General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The other contracts are specific to the homeless services provided. A Primary Medical Services (PMS) and Alternative Provider Medical Services (APMS) contract for delivering primary care to homeless patients. Under these two contracts the practice provides full registration and access to all primary care services to homeless people. For homeless patients who are frequent attenders to A&E or regularly admitted to Manchester Royal Infirmary a specific service known as Manchester Pathway (Mpath) has been established to reduce A&E attendance and the number of homeless people requiring hospital stays.

The practice has four GP partners and two salaried GPs, three practice nurses, one of whom works primarily with homeless patients, a health care assistant and a homeless team consisting of a manager, two case managers and a homeless health and housing worker.

UVMP is a training practice, accredited by the North Western Deanery of Postgraduate Medical Education and has three GP specialist trainees (GPST).

UVMP is situated within the geographical area of NHS North Manchester Clinical Commissioning Group (CCG). Ancoats is an area with high levels of deprivation.

UVMP is responsible for providing care to 10,000 patients of whom, 56.5 % are male and 43.5% are female. The percentage of patients from Black and minority ethnic background is 21%. The practice patients are predominantly working aged between 20 years and 39 years of age, higher than the national average.

The practice has over 700 homeless patients registered and approximately 200 patients with drug and alcohol dependency currently seeking treatment.

When the practice is closed patients are directed to the out of hours service, Go to Doc.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

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 23 June 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with 18 patients, including patients who were homeless, four members of the patient participation group and 17 members of staff. We spoke with a range of staff, including GPs, Specialist GP trainees, nurses, health care assistant, the homeless team, receptionists and the practice manager. Additional to the practice staff we also spoke with a social worker, district nurse and Manchester North cancer lead for MacMillan who work alongside the practice and their patients.

We reviewed 16 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)

Outstanding ☆

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed significant event reports. The investigations were comprehensive and actions taken were clearly recorded as well as changes made to practice when required. This information had been cascaded to staff during weekly meetings or sooner face to face communication where required. Where appropriate learning was also shared with partner organisations and commissioners. We saw the practice had managed these consistently over time which evidenced a safe track record over the long term.

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 investigated complaints, carried out a range of full clinical audits and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. This was evident from speaking with staff, reviewing minutes of meetings and speaking with external partners such as a social workers and district nurse, both of whom told us the practice were continually learning and reviewing operational systems to maintain safe care to patients.

The practice had a system in place for reporting, recording and monitoring significant events. We saw from the practice significant events log, minutes of meetings 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. Weekly staff meetings were in place where significant events and incidents were standard agenda items. All staff told us the practice was open and willing to learn when things went wrong.

We noted a number of examples of where change had taken place following a significant event and subsequent full clinical audits had taken place for example, appointments, infection control, cervical screening and Warfarin safety.

The practice had systems in place to respond to safety alerts, received by the practice manager and then National patient safety alerts were disseminated to appropriate clinicians for action. Alerts were discussed and actions to be taken were discussed at weekly GP and nurse meetings.

Reliable safety systems and processes including safeguarding

The practice had a detailed child protection and vulnerable adult's policy and procedure in place which incorporated information on the Mental Capacity Act 2005.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding.

All the staff we spoke with were able to confidently discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. Weekly safeguarding meetings were held at the practice and where required a health visitor and social workers would be in attendance to ensure good communication and all parties were up to date with relevant information linked to children and families welfare. Within the meetings the practice would review all paediatric A&E attendances and emergency admissions and review the current safeguarding register.

If reception staff had any concerns about a patient's welfare while at the practice, they could communicate these to clinicians prior to the patient being seen by the GP or nurse. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff and to encourage continuity of care.

The practice had a lead GP and deputy in place for child safeguarding and separate lead and deputy for adult safeguarding. We spoke with the lead for safeguarding children and deputy for adult safeguarding; they had completed training to level three and were knowledgeable

about the contribution the practice could make to safeguarding patients and were proactive in raising concerns to the Local Authority and police where required, with evidence recorded as part of safeguarding records. Clinical staff were aware of their roles to maintain patient's safety. These included areas such as domestic violence, child sexual exploitation, female genital mutilation and human trafficking.

We noted guidance was displayed for staff if they suspected a patient to be subject to domestic violence and posters were placed in public toilets which had tear off contact details of support services if patients were concerned about domestic violence. The practice worked as part of Identification and Referral to Improve Safety (IRIS). This was a general practice-based domestic violence and abuse training support and referral programme, working alongside local support agencies and providing private space within the practice for other organisations to meet with and support victims of domestic violence.

A chaperone policy was in place, and there were notices for patients in the waiting area and consultation rooms. Speaking with staff who acted as chaperones, they were clear of the role and responsibility and when a chaperone was declined or accepted the details were recorded within patient's records.

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

Medicines administered by the nurses and health care assistant 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.

Disease-modifying antirheumatic drugs (DMARDs) that are normally prescribed for rheumatoid arthritis were jointly planned and prescribed with the hospital consultants, with shared care protocols in place. The DMARDs were monitored and checked by a nurse and any changes were referred to a GP for action.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. Staff told us information and changes to prescribing were communicated during weekly clinical meetings. Staff told us they regularly discussed and shared latest guidance on changes to medicines and prescribing practice.

Speaking with GPs and reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals, such as NHS consultants and/or

following hospital discharge, the changes were reviewed by the GPs daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. 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, address of patient.

The practice had a number of strict policies in place in line with national guidance, in relation to Opioid Replacement Therapy Procedure, such as methadone. Policies and procedures were in place for polysubstance users, for example patients with alcohol and drug dependency and not prescribing benzodiazepines to patients who are polysubstance users. Staff we spoke with were fully aware of these policies.

Cleanliness & Infection Control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed. All the patients we spoke with were happy with the level of cleanliness within the practice.

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. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

Outstanding ☆

Are services safe?

A nurse took the lead for infection control and carried out routine audits. We noted from the audit carried out in March 2015 the practice were compliant in all areas. The practice produced an annual infection control statement in which they summarised any significant events, risk assessments, audit of minor surgery, patients being treated with MRAS (MRSA is a type of bacteria that's resistant to a number of widely used antibiotics) and staff training. We saw from the statement there had been two significant events including a needle stick injury and noted appropriate action was taken in line with the practice policy.

We saw staff had received infection control training; 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. Reception staff had access to gloves and alcohol gel if required when receiving samples from patients.

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

Cleaners were employed by a building management team who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis and the practice held a copy. We looked in several consulting rooms including the minor surgery room. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw the dignity curtains in each room were disposable and labelled showing when they required replacing.

Equipment

The practice manager ensured all equipment was effectively maintained in line with manufacturer's guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

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.

A panic alarm system was in place in consulting rooms and behind reception 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 three 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 to ensure patients were protected from the risk of unsuitable staff.

Safe staffing levels had been determined by the practice for both clinical and support staff and rotas showed these were maintained. The practice had recently recruited additional administration/reception staff after identifying work pressures following staff sickness.

Within the homeless team they identified the need for a worker with housing specialisms to allow the practice to improve patients' social situations, as there was clear evidence of the improved health outcomes of people in stable accommodation. Their role was to identify and assess patients admitted to the Manchester Royal Infirmary who were homeless and assist with accommodation, benefits, GP registration, clothing in order to achieve appropriate discharge, in order to reduce the number of presentations to hospital. Evidence showed that in the first six weeks of the worker being appointed, temporary short term accommodation was found for 12 patients to enable discharge; alcohol/drug free accommodation was secured for three patients.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. All identified

risks were recorded and assessed. The practice manager ensured action was taken to reduce any of the identified risks, and all information was disseminated to staff during meetings.

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs, and nurse had been allocated lead roles to make sure best practice guidance was followed in connection with patient care and treatment for example diabetes, sexual health, homeless health care, mental health and palliative care . The GP partners took joint responsibility for clinical governance, with two GPs taking the lead for safeguarding and a nurse taking the lead for infection control. The practice manager took the lead for human resources.

Speaking with staff and reviewing minutes of meetings we noted safety was being monitored and discussed routinely. Appropriate action was taken to respond to and minimise risks associated with patient care and premises. We saw evidence that staff received annual cardiopulmonary resuscitation (CPR) training.

Policies, procedures and staff training were in place to support staff in managing patients exhibiting challenging behaviour, including intoxicated patients. For some patients alerts were placed on patients files to alert practice staff to call staff from the homeless team who had a relationship with those patients and were able to engage with them to prevent any heightened anxiety.

GPs would contact patients with blood test results where patients required follow up treatment. For homeless patients details would be passed to the homeless team, who through networks and knowledge of the homeless population in Manchester would attempt to locate patients and support them to access the practice to receive the appropriate treatment.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice manager and GPs kept a copy of this plan at their homes in case they could not access the building for any reason.

We saw fire safety checks were carried out and full fire drills had been carried out. 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 dealing with medical emergencies including CPR.

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. We were told following any medical emergency staff were involved in a debrief session.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches.

They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. Implications on practice performance and patients were discussed and required actions were agreed. We saw that the actions were designed to make sure that each patient received the support required to achieve the best health outcome for them. We saw that GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Staff had access to a range of journals, reference books with which they could refer and online resources to keep up to date with current best practice. New areas of research relevant to the work within the practice included the work with the homeless population. Staff discussed how they utilised these resources to provide evidence based care and treatment for patients, and referred to these resources where they had complex situations or new conditions which required care and treatment. Speaking with one patient they told us their GP researched and spent time to understand their rare condition and took an active interest in the care and treatment they were receiving in hospital to fully understand the condition.

We found from discussion with GPs, nursing staff and the homeless case managers they completed thorough assessments of patients' needs in line with guidelines, such as NICE guidance and guidance from the Faculty of Homeless Health. We were provided with a number of examples where the practice had made changes to the care and treatment of patients in line with update guidance from NICE including management of patients with Hepatitis C.

The GPs told us they led in specialist clinical areas such as diabetes, asthma, female health, sexual health, and two GPs led the homeless healthcare work. This allowed the practice to have leads in areas to support them in delivering the best outcomes for patients. For example the diabetic clinic had been running since the 1980s and now there was an experienced practice nurse supporting the clinics. We saw from The National Quality Outcome Framework (QOF) 2013/14 the practice were performing above the local average with 91% of outcomes achieved.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support, GPs met daily to discuss patient care and clinical issues. Staff told us this supported them all to continually review and discuss new best practice guidelines and manage patients with complex healthcare needs.

Speaking with the practice nurses they explained to us how they reviewed patients with chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) on an annual basis. Patients with long term health conditions were recalled by letter and calls were made to patients the day before appointments to remind them to attend. We saw from The National Quality Outcome Framework (QOF) outcomes for patients had been achieved above the local average and national average, which included adults being reviewed annually.

For homeless patients with long term health conditions the practice worked as a team with the support of the homeless case managers and the networks they had established across the city to find people. This involved letters to hostels, the nurse attending day centres and outreach sessions to ensure wherever possible, homeless patients had the same access to annual reviews as any other patients.

For those patients with learning disabilities the practice carried out full health checks and provided patients with written care plans based on the Cardiff Health Check (CHC) . The CHC is a nationally recognised template approved by The Royal Collage of General Practitioners. During 2014/15 90% of the patients on the learning disabilities register had received an annual health check and a written care plan. The remaining 10% were homeless patients and alerts were placed on their records showing reviews required.

The QOF provided evidence that the practice were above local and national averages when responding to the needs of people with dementia, including those newly diagnosed. For those patients with dementia 87% had their care reviewed in a face-to-face review in the preceding 12

months. For patients with poor mental health data showed 87% of those diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the records.

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

Staff were able to describe how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005, with guidance available in the Mental Capacity Act policy and consent policy.

Discrimination was avoided when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race, culture, disability and social circumstances as appropriate. We saw many examples of this, particularly with regard to person centred care, this was corroborated by the patients we spoke with and the comments we received.

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 or chronic obstructive pulmonary disease (COPD). We were shown patients were provided with COPD plans and asthma plans were in place for children using the template developed by Asthma UK. For those patients with COPD the practice nurse reviewed those patients regularly ensuring they had exacerbation rescue packs at home and were followed up after an admission to hospital 94% of patients had COPD care plans in place and all other patients had either declined or were not suitable for self management plans. The practice were working with all children under 18 to have self management plans in place, with 67% completed. Children were provided with two copies of the plan, one of which they were to take into school and pass to teachers allowing schools to support children in managing their asthma.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes. Speaking with staff they told us they benefited from regular clinical meetings, to share knowledge and discuss patient care.

The practice has provided primary care to homeless people in Manchester for over 15 years. The practice had a wide range of services for patients to improve their health outcomes including access to weekly multidisciplinary drop-in clinics, drug workers, homeless case managers, leg ulcer clinics and infectious disease clinic to facilitate access to Hepatitis C and Blood borne virus treatment. Additional to these in house primary and secondary care services the practice had also established The Manchester pathway (Mpath) a hospital in-reach service at Manchester Royal infirmary (MRI). Staff from the homeless team visited MRI, to assess homeless patients who were frequent attenders at Accident and Emergency (A&E) or current inpatients to ensure they were discharged with a package of care, housing, engaged with primary care services and did not re-attend A&E unnecessarily.

The practice provided support to approximately 200 patients in relation to substance misuse in partnership with Manchester RISE the substance misuse service. As part of this work and in the knowledge that a high proportion of injecting drug users have Hepatitis C, a shared care fortnightly consultant led clinic was established in 2011 with a significant number of patients receiving treatment with successful outcomes.

The practice was making use of clinical audit tools and evaluations. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. Staff spoke positively about the culture in the practice around audit and quality improvement. We saw for example an audit of Intra-uterine contraception and the number of women attending the nationally recommended six week checkup. Results showed a 40% increase in the women attending for checks following the actions set out in the audit.

The practice actively used the information they collected for 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. Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 92% of outcomes achieved

above the local average. Results showed the practice were supporting patients well with long term health conditions such as, asthma, diabetes and heart failure above the local average.

Patients told us they were happy that 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

Practice staffing included medical, nursing, managerial, a homeless team and administrative staff. We saw that all new staff, from GPs to receptionists were provided with formal induction to the practice.

We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support, safeguarding and infection control. Staff were supported to complete additional training and gain additional qualifications, this included nurses trained in initiating insulin for diabetic patients.

A good skill mix was noted amongst the GPs, where we saw a range of specialist skills including, training, women's health, family planning and diabetes. The lead GP had recently been appointed to the Royal College of General Practitioners sexual health and Blood Borne Virus Group.

Patients had an option of seeing male or female GPs.

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

The practice manager had a training matrix in place so they could see at a glance what training each staff member had had and when it needed to be updated. 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.

The practice had a system for supervision and appraisal in place for all staff. All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs were identified. 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.

Working with colleagues and other services

We found the GPs, nurses, health care assistants, homeless team and practice staff 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 provided the largest substance misuse shared care service in the city, run in partnership with Manchester RISE, the centralised drug service for the city.

The practice were proactive in building business cases to provide additional services for patients. This included a Leg ulcer clinic which commenced in April 2014 and was accessible to patients who were not registered with the practice. Since commencement of this service 796 treatments had taken place with 733 of those being homeless patients that would not otherwise attend a clinic.

The practice had a number of shared care initiatives delivered in house which included a consultant led Hepatitis C and Bloodborne virus clinic.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place as part of the cancer improvement scheme to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held monthly with other health and social care providers. Cases were discussed regularly between clinical staff to ensure patients and relatives were reviewed on a regular basis to meet their physical and emotional requirements and ensure that whenever possible they ended their lives in the place of their choosing. Speaking with a district nurse and the Manchester North Cancer lead for MacMillan they told us the whole practice embraced good quality end of life care and corroborated what we were told by the practice. For patients nearing the end of life care plans were in place which included the preferred place of care and preferred place of death.

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice received blood test results, X ray results, and letters from the local hospital including

discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. The practice had a system to monitor patients they knew were in hospital and proactively check if they had been discharged, rather than wait for formal notification. This helped to ensure that home visits, update appointments and reviews to medicines could be done in a timely manner.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life' care. Information was scanned onto electronic patient records in a timely manner. Electronic systems were also in place for making referrals.

The Practice work as part of the North Manchester Integrated Neighbourhood Care (NMINC) with monthly Multi-Disciplinary team meetings (MDT) working with active case managers, district nurses, social workers, and mental health professionals took place. We saw from minutes of meetings, speaking with staff and external partners, these meetings reviewed patients on the 'at risk' register, a register of patients at risk of unplanned hospital admissions. During meetings appropriate care and interventions for patients were agreed and where required care plans updated. The care plans were accessible to all partners via a secure computer system to ensure continuity of care.

There was a schedule of meeting in place for the practice which included daily briefing sessions before surgery, weekly homeless service meetings, weekly GP and nurse meeting, weekly administration meetings and weekly child safeguarding meetings. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions.

There was a practice website which provided a wide range of information for patients and links to other services available locally and nationally. Information was also kept up to date on the website with the latest practice news and links to the work of the patient participation group (PPG).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Childrens' Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. This included best interest decisions, deprivation of liberties and do not attempt resuscitation (DNACPR)

Policies and procedures were in place to support staff in meeting the needs of patients for whom capacity to consent was in doubt, for example with making DNACPR orders or best interest decisions. This policy highlighted how patients should be supported to make their own decisions and how those should be documented in the medical notes. We were provided with a number of examples where practice staff had initiated capacity assessments for patients and instigated best interest meetings to ensure patients received the best care and treatment at the time it was required.

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's 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.

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. Gillick competency allows professionals to demonstrate they have checked the person's understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. The practice had a Gillick competencies checklist for staff to refer to if they were unsure about the process to follow. Speaking with the practice nurses they routinely saw young people unaccompanied and used the Gillick competency to assess their understanding. Where capacity to consent was unclear they would seek guidance prior to providing any care or treatment.

We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes and included vaccinations.

We were told for patients where English was their second language, the practice had access to pre-bookable

translation services or if required immediately a telephone interpretation service. British sign language interpreters could be arranged if necessary. Staff told us friends and relatives were not used to interpret unless specifically requested by the patient. This was to ensure they were supported to provide voluntary and informed consent to treatment. This was in line with good practice to ensure people were able to understand treatment options available and give informed consent. We saw during the inspection pre-booked translators had been arranged for deaf patients and Non English speaking patients.

Health Promotion & Prevention

The practice had a range of written information for patients in the waiting area. Information was available for patients to take away on a range of health related issues, local services and health promotion. A wide range of information was available on the practice website, with links to local and national support groups patients could access.

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check. New patient assessments were done by the practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice analysed the outcomes of newly registered homeless patients who attend for new patient health care assessments (NPHC) between June 2014 and June 2015 with 100 new patient registrations sampled. Registration for homeless patients included, blood pressure measurement, height/weight/BMI, cardiovascular disease, smoking status, alcohol intake, sexual health and risk reduction advice. From the sample they found 5.5% of male patients as having Type2 diabetes then enabling the practice to initiate treatment and 61% of women were diagnosed as Hepatitis C antibody positive.

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 noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. We were told health promotion formed a key part of patients' annual reviews and health checks and included discussions and assessments of a patient's mental health. Support in achieving healthy lifestyles included walking groups, smoking cessation and weight management, referrals to health trainers and other community programmes such as 'fit4work'. The practice had also identified the smoking status of 90.6% of patients over the age of 16 and actively offered smoking cessation with the health care assistant.

The practice ran a campaign during October 'Socktober' in which they encouraged donations of socks that they gave to the homeless who attended the practice, to help maintain healthy feet and support patients suffering from conditions such as trench foot.

The practice's performance for cervical smear uptake was 74% 2013/14. The practice had identified a lower than average uptake of cervical smears within certain population groups such as HIV positive women and female drug users. Following an audit we saw that a multidisciplinary approach by practice staff and drugs workers had a positive impact with a 10% increase in uptake among drug using patients. Linked to this audit the practice looked in more detail at the uptake of smears for HIV positive women who are at greater risk of cervical cancer. Many within this population group were homeless, which meant the national recall scheme was not reaching these women. From this the practice introduced a code into patient's records, prompting the need for annual cervical smear tests aiming to increase the uptake within this population group.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was the same or above average for the CCG, and again there was a clear policy for following up non-attenders.

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

Outstanding ☆

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 observed staff to be comfortable and confident in supporting all patients including those with challenging behaviour.

We spoke with 18 patients and reviewed 16 CQC comment cards received the week leading up to our inspection. All were very positive about the level of respect they received and dignity offered during consultations. Statements used to describe the care and treatment people received included: 'excellent care', 'always brilliant and very helpful' and 'respected and feel staff care'.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at reception and a back office. Staff told us and we observed, where any private conversations were required these were transferred to the back office to maintain privacy.

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

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

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. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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 a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 94% of respondents found the receptionists at this surgery helpful above the local CCG average. We saw all phone calls from and to patients were carried out in a private area away from the reception and waiting area to maintain patient confidentiality.

Care planning and involvement in decisions about care and treatment

The care and treatment provided by the practice to the whole, diverse patient population was very holistic and took account of patient physical, social and emotional needs such as employment, housing status and lifestyle which affected physical and mental health. All the patients we spoke with told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. These comments were reflected in the GP national survey which showed, 98% said the last GP they saw or spoke to was good at giving them enough time and 92% said the last GP they saw or spoke to was good at involving them in decisions about their care. Both of these figures were above the local average.

Patients we spoke with on the day 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, acknowledging where appointments were not urgent if they wanted to see a specific GP there may be a wait.

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 survey in which 98% said the last GP they saw or spoke to was good at listening to them and 94% said the last nurse they saw or spoke to was good at listening to them again above the national and local average.

The practice had 163 patients on its Mental Health register. The Practice had recognised the uptake rate of annual health screening and care plans for patients with mental health problems was lower than expected, due to poor engagement with patients despite regular appointment invites. This had been addressed by allocating the role to the Homeless service manager to ensure Mental Health Care Plans were in place for as many patients as possible on the register. Data from the practice showed in 2014/15 76% of patients on the mental health register had a care plan and 78% had a physical health check such as alcohol score, blood pressure and cervical screening test. We were told this work was on-going to ensure the needs of patients with poor mental health had access to reviews and treatment.

We saw care plans were also in place for patients at risk of unplanned hospital admissions, patients with learning disabilities, and those aged 75 and over who were vulnerable and patients at the end of life. For patients on the 'at risk' register which is those patients at risk of unplanned hospital admissions, 100% of these patients had detailed care plans in place, which were reviewed by their named GP and care coordinator every three months or three days after a hospital admission, whichever was sooner.

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.

Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities and patients who required an interpreter to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

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

From the GP national survey 98% 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% said the last nurse they saw or spoke to was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the CQC comment cards we received were also consistent with this survey information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required. We observed all staff engaging positively with patients on the day of our inspection, including vulnerable patients who came into the practice just to chat with reception staff.

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. Patients and their family members who had recently been bereaved would be contacted by a GP best known to the family and where necessary a GP would carry out a home visit or invite relatives into the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice held registers of patients with chronic disease, those at risk of unplanned hospital admissions and patients with learning disabilities to monitor patients' needs and outcomes and provide a responsive service. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice had an understanding of their patient population, including the needs of the 700 plus homeless patients registered with the practice. The practice engaged with NHS England and they engaged with the North Manchester Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised, putting forward successful business cases to provide additional in house provision for patients such as a leg ulcer clinic and Blood Bourne Virus clinics.

In addition to the well established services provided to homeless patients, the practice elected to provide additional enhanced services to help meet patients' needs for example, facilitating timely diagnosis and support for people with dementia scheme, minor surgery, learning disabilities health check scheme and services for violent patients. The enhanced services and additional needs of the patient population were standard agenda items at practice meetings to support the practice to continually improve and meet the challenges of the patient population.

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

The practice were proactive in supporting the needs of non English speaking patients, providing them access to face to face interpreters or telephone interpretation. The practice had recognised that provision for deaf patients needed to be improved and were looking to introduce an email access system for those patients hard of hearing. Speaking with a deaf member of the patient participation group, access and making emergency appointments was an area of concern which they were hoping to work with the practice to improve.

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 opportunistic appointments, health checks and screening when patients presented at the practice. We were told this flexibility was particularly important for homeless patients or sex workers to offer holistic health screens when patients attended as they may not attend again for long periods of time. The practice also offered home visits. Home visits were provided by GPs, nursing staff and health care assistants.

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

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 has two patient participation groups one for homeless patients and a virtual patients participation group (VPPG. From April 2015 this was extended to also included face to face meetings. There were 92 members of the VPPG, from a diverse age range and social economic backgrounds. The group had supported the practice to help with current developments such as online access to medical records and updates to the practice website. The VPPG had identified a lack of representation from homeless patients and as a result the practice developed a homeless group. This started with questionnaires during homeless drop in clinics and developed to face to face meetings. At those meetings the group set out priority areas they would like to work on alongside the practice, such as, requesting access to a drink of water i.e. water cooler during the drop in clinic.

We met with four members of the VPPG who were positive about the practice and the development of face to face meetings. They told us an initial meeting had been held but as yet no priorities had been set. They told us they felt welcomed, listened to and involved in its development and were looking forward to supporting the practice to make improvements and meet the needs of patients.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had taken steps to ensure equal access to patients regardless of circumstances. Speaking with staff and the lead GP the philosophy of accessible health care to all was clearly evident. This was also evident from the patients we spoke with and feedback received from comment cards.

The practice was on one level, was accessible for patients with disabilities and had disabled parking spaces available. 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. However we observed one patient accessing the practice using a wheel chair experienced difficulty. A disabled toilet was available as were baby changing and breast feeding facilities. The website was accessible, and could be translated into different languages if required.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice ensured that for patients where English was their second language they had easy access to an interpretation service. Information was available in different languages, accessed via the website. We also noted for hard of hearing patients a hearing loop was in place and translators were booked.

The practice had achieved Gold, the highest award in the NHS 'Pride in Practice' award from the Lesbian, Gay, Bisexual and Transgender Foundation, which demonstrated the practice's commitment and dedication to ensuring a fully inclusive patient-centred service.

Access to the service

Appointments were available 8:00am and 6:00pm Monday to Friday, with a specialist drop in clinic for homeless patients on a Wednesday afternoon. Appointments could be pre booked up to 4 weeks in advance and were bookable online, via the telephone or face to face. The practice had 50% of appointments bookable on the day for urgent care needs including appointments for children and vulnerable patients. The practice told us no patients were ever turned aware and where necessary GPs were flexible and frequently saw patients past clinic times. We observed patients being booked in to see GPs beyond the clinic times during our inspection. Patients also had access to GP telephone consultations and wherever possible this was with a GP familiar with the patient.

For homeless patients alongside accessing appointments throughout the week, there was a weekly multi agency drop-in, run by the homeless team. On average 80 patients attended the drop-in with access to GPs, practice nurse, mental health worker, community psychiatric nurses, Tissue Viability Nurse, drug workers, specialist care manager, community alcohol team worker and a dentist.

The homeless team including a practice nurse provided access to care and treatment in outreach settings to enable homeless patients to have access to health checks and vaccinations. The homeless team were also able through local networks, to locate homeless patients who required treatment. For example if patients required reviews or treatment following blood tests the homeless team would, wherever possible, locate people and support them to access the surgery.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, they would be redirected to the out-of-hours service.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were provided to those housebound patients by GPs and nurses for both urgent and routine conditions and annual reviews.

The patients we spoke with were satisfied with the appointment system, although some patients, who worked, would like appointments available either early mornings or evenings so they do not have to take time of work to attend appointments. We saw from the GP national survey 95% found it easy to get through to the surgery by phone, 85% were able to get an appointment to see or speak to someone the last time they tried and 98% said the last appointment they got was convenient, all above the local CCG average.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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 was a designated responsible person who handled all complaints in the practice.

We saw there was a complaints procedure in place. We reviewed the complaints register which included verbal and written complaints and looked at a sample of written 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.

The practice reviewed complaints to detect themes or trends over the year to learn and improve services. We noted complaints and learning/actions following complaints were standard agenda items of practice meetings.

Complaints information was displayed and available on the website and within the practice leaflet. 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 robust 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 and shared with other stakeholder where appropriate such as the CCG and Local Authority.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice philosophy was clear and well established to ensure equality of access for all to primary healthcare. This philosophy was driven by the management team and embraced by all practice staff. The practice had recently reviewed their vision and strategy, actively involving all staff during a vision session. As a result the following vision was agreed. 'We are a professional progressive GP practice providing a high quality range of primary care services to a diverse population with a focus an inclusion and quality.'

The practice and all its staff were clearly proud of the service they provided to patients and the work they undertook to enable vulnerable and homeless patients have access to primary health care. They worked consistently to ensure that resources were delivered to the diverse population, putting forward business cases to enhance services for example Hepatitis C clinics. They aimed to provide services that meets the needs of the entire community and achieved this by delivering care that was person centred and holistic.

We spoke with 17 members of staff and they all knew and understood the vision and values of the practice and their responsibilities in relation to them. Staff we spoke with said the practice was really special and everyone was signed up to the aims and objectives.

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

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, were comprehensive and reflected up to date guidance and legislation. We noted policies and procedures were in place to support staff in managing challenging behaviour and intoxicated patients.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; GP leads for safeguarding children and adults. Lead GPs and manager for the homeless services, lead GP for sexual health and family planning and practice nurses took lead roles in the management of long term conditions. We spoke with 16 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 had a programme of meetings in place which included weekly GP partner meetings, covering general management issues and strategic decision making. Weekly nurse and GP meetings took place in which clinical updates, significant events and alerts were discussed. The homeless team held weekly meetings and multi-disciplinary meetings were held monthly in relation to palliative care and patients who were at risk of unplanned hospital admission and care panning. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice used a range of data and intelligence available and worked alongside the CCG, public health, local authority and voluntary organisations to improve outcomes for patients The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed that in 2013/14 they had met 92% of the outcomes, above the local CCG average.

The practice had a full clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of completed audits. These included clinical and non clinical audits such as appointments and infection control. Clinical audits included cervical screening, Warfarin safety and Hepatitis C treatment. We saw from all audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during team meetings and re-audited to ensure changes had been implemented.

The practice had robust arrangements 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. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Are services well-led?

Outstanding ☆

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

Leadership, openness and transparency

A clear leadership structure was in place with named members of staff in lead roles. The practice had clearly set out leadership and governance roles among the partners, with managers, GPs and nurses taking a lead role in different areas for example, training, homelessness, safeguarding, palliative care and quality monitoring.

We saw from minutes that team meetings were held regularly, with an annual meeting programme set out The annual programme included partner meetings, administration meetings, GP partner meetings and safeguarding. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, or with colleagues as and when required. Staff told us there was never a time when there was no one to speak to seek support, advice or guidance and where there had been difficulties, views and opinions were listened to.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, a recruitment policy and a training policy, were in place to support staff. We were shown the staff handbook that was available to all staff which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment Staff we spoke with knew where to find these policies if required.

All staff had an appraisal meeting, giving staff the opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. All staff we spoke with confirmed they had had an appraisal and the nursing staff told us they had joint appraisals with the practice manager and a GP. Staff had access to supervision with line managers and a system of monthly supervision was in place for the homeless team which they valued.

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

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

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

We reviewed the results of the GP national survey carried out in 2014/15 and noted 96% described their overall experience of the practice as good. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services) We saw in up until June 2015 total of 544 responses, 77% of patients selected that they would be extremely likely or likely to recommend the GP practice to friends & family if they needed similar care or treatment and 12% wouldn't recommend the practice. The majority of comments were extremely positive about the care and treatment patients had received. The results of the FFT were displayed on a television screen in the waiting area.

The practice had a Virtual Patient Participation Group (VPPG) which was made up of a diverse range of patients. The group had supported the practice to help with current developments such as online access to medical records and updates to the practice website and to discuss ways in which patient experience could be improved. The actions and outcomes from the VPPG and the homeless participation group were displayed on a television screen in the waiting area in a 'you said', 'we did' format.

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 in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and spoke with 17 staff and noted that regular supervision appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities. From staff records and speaking with staff they told us they regularly attended

Are services well-led?

Outstanding ☆

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

training courses. Mandatory training was arranged for staff and they were able to request relevant training courses that would enhance their performance at work. Clinical staff told us they were supported to maintain their continual professional development (CPD). Staff told us they felt very well supported at work and that the practice had an open door policy so they could raise any concerns.

The practice was a GP training practice with three GP specialist trainees. Speaking with the trainees and looking at past evaluations the feedback with regards to the support and learning opportunities provided by the practice was positive. We noted one GP had been given a silver award from the University in 2013 for Excellence in teaching Medical Students.

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