Cornerstone Family Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cornerstone Family Practice on the 4 June 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, effective, caring, and well led services.

It was also good for providing services for the populations groups we rate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored and reviewed.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned in line with best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they could make an appointment with a named GP, with urgent appointments available the same day.
- The practice was equipped to treat patients and meet their needs.
- Staff felt supported by management.

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

The provider should:

- A more robust programme of clinical audits should be developed to demonstrate positive outcomes for patients.
- Prescription pads should be securely stored.
- The lead for safeguarding should complete training to level 3.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses and lessons were learned. Information about safety was recorded, monitored and reviewed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patient's needs were assessed and care was planned and delivered in line with current legislation, this included assessing and promoting good health. Staff had received training appropriate to their roles. The practice had a number of enhanced services, including learning disability health checks, avoiding unplanned admissions and dementia enhanced services.

Are services caring?

Good

The practice is rated as good for providing caring services. The partnership was made up of four GPs. Patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment. Information was provided to help patients understand the services available to them. Staff treated patients with kindness and respect, and maintained confidentiality. Clinical staff were committed to providing good patient care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was equipped to treat patients and meet their needs. There was an accessible complaints system.

Are services well-led?

Good

The practice is rated as good for well-led. It had vision and strategy. Staff were clear about the vision and their responsibilities in relation to the practice. There were policies and procedures in place to govern activity. There were systems in place to monitor safety and identify risk. A system for staff appraisals was in place but needed to be developed further. The practice had a number of informal governance arrangements which included face to face meetings between the partners; however discussions and decisions made at these meetings were not always recorded.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people registered with the practice and had a range of enhanced services, for example, avoiding unplanned admissions to hospital and dementia. All older patients had a named GP and were screened for dementia. Older patients with complex care needs are discussed at the North Manchester Integrated Care meetings held at the practice and attended by GPs, practice nurses, district nurses, palliative care nurses and social workers.

The practice offered annual flu and pneumococcal vaccinations and the shingle vaccinator for people aged 70 years.

The practice offered home visits and visits to people who lived in care homes. The practice provides end of life care to palliative patients in their homes or place of choice and works with the district nursing team and palliative care teams.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice has a recall system in place to ensure patients are called for an annual review so the condition can be monitored and reviewed. GPs and practice nurses reviewed patients with chronic diseases, including regular blood/urine checks. Patients whose long term conditions leave them at increased risk of hospital admission are covered by the 'Unplanned admission' enhanced service. The practice is proactive in offering flu and pneumococcal vaccination to those eligible or in at risk groups. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. Midwife clinics are held weekly and patients care is shared between the practice and a local hospital.

Sick children are seen as soon as possible.

GPs held twice weekly baby clinics. Nurse led immunisation clinics for young children were held weekly.

Summary of findings

New mums are invited to attend for a post natal check after six weeks when post natal depression is also monitored.

The practice worked periodically with midwives, health visitors and school nurses when required.

Baby changing facilities and breast feeding facilities were provided.

Systems were in place for identifying and following-up vulnerable families and who were at risk.

The practice was aware of children on protection registers and used an alert system within the patient record to alert staff to the child's attendance in surgery. Staff knew what action to take if they had concerns about a child.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Health screens are offered to those patients aged 40+ which includes blood tests and blood pressure monitoring. Patients are offered screens for sexually transmitted diseases and contraceptive advice given. Chlamydia screening is offered to young people.

Access to alcohol screening, smoking cessation and support with weight management was promoted to enable patients to make healthy lifestyle choices.

Online prescription ordering and online appointment booking were available through the practice website and could be accessed by all patient groups.

The practice is part of the Northern Healthcare Federation and provides extra appointments to patients between 6pm and 8pm Monday to Friday.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice participated in a learning disability DES (Dedicated Enhanced Service), which meant patients who had a learning disability were invited to attend an annual review with a GP and longer appointments were provided to ensure this patient groups needs were fully assessed.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding

Summary of findings

information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. For patients where English was their second language, access to language line and interpreters was available.

People experiencing poor mental health (including people with dementia)

Good 

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received an annual health check. Routine blood tests are completed and Lithium monitoring that includes quarterly blood testing and an annual ECG. (Lithium Carbonate is a medicine which is used in depression, bipolar disorder, mania and self-harming behaviour. Patients in this group were offered longer appointments.

Summary of findings

What people who use the service say

We received 23 CQC patient comment cards and spoke with five patients at the time of our inspection visit. We spoke with older people, working age people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

Patients told us the practice was always bright and clean. They told us reception staff were helpful, friendly and cheerful. Patients told us they had received excellent support following bereavement.

Patients we spoke with told us they were involved in deciding the best course of treatment for them and they fully understood the care and treatment options that had been provided. They told us they had used the open access surgery for emergency treatment and appreciated the availability of these appointments. Other patients told us that they sometimes waited up to two weeks to see a GP of their choice but they knew other GPs were available.

Patients told us that during consultations with GPs they felt listened to.

We looked at feedback from the GP national survey for 2014/2015. A total of 423 surveys were sent out to patients and 138 were returned this is a 33% completion rate. Findings from the survey included 77% of patients said they would recommend this practice to someone new to the area, 93% of respondents find the receptionists at this practice helpful compared with the local average of 85% and 98% of respondents said the last nurse they saw or spoke to was good at listening to them compared with the local average of 91%.

Areas for improvement

Action the service SHOULD take to improve

- A more robust programme of clinical audits should be developed to demonstrate positive outcomes for patients.
- Prescription pads should be securely stored.
- The lead for safeguarding should complete training to level 3.

Cornerstone Family 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 and a practice manager specialist advisor.

Background to Cornerstone Family Practice

Cornerstone Family Practice is located in the Beswick area of Manchester, within the North Manchester Clinical Commissioning Group (CCG.) The practice was responsible for providing treatment to approximately 6030 patients registered at the Cornerstone practice. The practice also has a branch surgery located in the Audenshaw area of Manchester and 1926 patients were registered at the branch practice. We did not inspect the branch practice on this inspection visit. The practice is located in a purpose built building that is shared with other healthcare providers including dental services and community physiotherapy services. All patient treatment rooms are located on the ground floor. There is a large sized comfortable patient waiting area. The building is suitable for disabled patients and those who use a wheelchair. There is disabled toilet in the patient waiting area which also provides baby changing facilities. A hearing loop is located in the patient reception area.

The partnership comprises two male GPs and two female GPs, two practice nurses, one of whom is located at the branch surgery. The practice was supported by a practice manager, deputy practice manager, receptionists and secretaries.

The practice is open Monday to Friday, from 8.45am to 6pm and closed Wednesday afternoon.

The practice operated open access surgeries every morning apart from Wednesday, between the hours of 8.45 and 10.15am.

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

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

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.

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes (QOF) framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 4 June 2015. During our visit we spoke with a range of staff that included GPs, a practice nurse, reception staff and the practice manager. We spoke with staff from the district nursing team and we spoke with patients who used the practice. We reviewed policies, procedures and other information the practice shared with us before the inspection day. We reviewed CQC patient comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents.

We reviewed records including significant event report, complaints and minutes of practice meetings and multidisciplinary meetings, which demonstrated that the practice had systems in place that provided an opportunity to review practices and procedures.

Bi-monthly practice meeting were held and GPs met monthly with practice nurses to discuss incidents, staff training and patient care. Multi-disciplinary integrated care meetings were held every six weeks to discuss and plan joint interventions health and social care interventions for specific patients.

Practice nurses attended external nurse forum meetings and met informally to discuss practice issues, but a record of these meetings was not kept.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, including regular contact with other health and social care professionals where required. We saw a system was in place to ensure reviews took place in a timely manner for patients who required an annual review as part of their care.

There were strategies in place for patients that were frequent attendances at hospital emergency departments. These included making contact with patients to identify possible risk factors, reasons for attendance and considering what measures and or actions could be put in place to support and change patient behaviour. Patients who were frequent attenders could were discussed at the six weekly integrated care meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried out. There was evidence that the practice had learned from these and that the findings were shared with relevant staff, for example, in respect of information recording on patient electronic records. Staff told us the practice was open and willing to learn when things went wrong and findings were always shared with relevant staff.

We were told that significant events were discussed at practice meetings and GPs meetings, though we noticed from records that we looked at significant events did not appear to be a regular agenda item.

GPs received national patient safety alerts directly and the practice manager distributed these to nursing staff and non-clinical staff electronically. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They told us alerts were discussed at practice meeting and GP meetings, though we noticed from records that we looked at this was not a regular agenda item.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a child protection policy and a vulnerable adult's policy. The practice followed Manchester City Council safeguarding policy and protocols for both children and adults. We found GPs at the practice were knowledgeable about the contribution the practice made to multi-disciplinary child protection work. Staff we spoke with, clinical and non-clinical told us that they knew what action to take if they had concerns about a patient and what action to take in the absence of the lead GP for safeguarding and arrangements were in place to share safeguarding concerns with NHS and local authority partners and this ensured a timely response to concerns identified.

One of the GP partner's was the safeguarding lead, however the lead GP had not completed safeguarding to level 3 and neither had any of the other GPs who practiced. We discussed this with the practice who took action and arranged for one of the GPs to complete safeguarding Level 3 training before the end of June 2015.

Good

Are services safe?

Within the patient record system there was an alert system which alerted GPs, nursing staff and reception staff to any ongoing child protection concerns and systems were in place to monitor children or vulnerable adult's attendance at accident and emergency departments or missed appointments.

The practice had a chaperone policy and this was displayed in the patient waiting area, (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff acted as chaperones when required. They told us they had been trained by GPs and knew to stand within the dignity curtain area. GPs knew to record within the patient record when a chaperone had been used and who had acted as a chaperone. Patients we spoke with were aware of this service but none had direct experience of it.

Medicines management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations. Emergency medicines for cardiac arrest were available within the building and were stored securely in the reception area. Records of monthly checks were maintained. Systems were in place for the management of medicines including medicines management policies. We checked medicines stored in the treatment room and fridge. We found that they were stored appropriately. Vaccine stocks were well managed and in date. Fridge temperatures were recorded and monitored. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by the practice nurse using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nurse had received appropriate training to administer vaccines.

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

The practice had guidelines in place for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 48 hours.

Patient medication recall systems were in place for annual medicine reviews and changes recorded in patient's electronic records.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not always handled in accordance with national guidance, for example, there were no audits in respect of blank prescriptions kept in GPs bags. There was no auditable system for reviewing and monitoring the recording of serial numbers on all blank electronic and hand written prescriptions pads held in storage and once allocated to GPs. The practice manager and GP assured us this would be addressed as soon as possible.

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

Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by GPs. Systems were in place to prevent patients re ordering repeat prescriptions before the due date. An electronic system for repeat prescriptions was available for patients.

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

Cleanliness and infection control

Patients we spoke with told us the practice was 'always clean and tidy'. There were systems in place that ensured the practice was regularly cleaned. We saw that the practice was clean throughout and appropriately maintained.

We found the practice had a system in place for managing and reducing the potential for infection. An Infection Control Policy was in place, along with protocols for the safe storage and handling of specimens. Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely.

Good

Are services safe?

A practice nurse took the lead for infection control within the practice. We found the practice to be clean at the time of our inspection and there was a cleaning contract for the building in place. We also saw cleaning checklists were in place and regularly completed.

Protective equipment such as gloves, aprons and masks were readily available. This was to protect both patients and staff from exposure to potential infections. Examination couches were washable and were all in good condition. Some chairs in treatment rooms needed to be replaced as fabric was worn and foam interiors were exposed which carried an infection control risk. Each clinical area had a sharps disposal bin that was positioned out of reach to children. Sharps bins included the date of when it had been opened.

Hand washing facilities were available and notices about hand hygiene were displayed in staff and patient toilets. Liquid soap and paper towels were provided in these areas.

The storage and use of medical instruments complied with national guidance. The practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

Equipment

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

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

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

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing and recruitment

We were told the staff group at the practice was a stable one and no new staff had been appointed in the last three years. The practice had a recruitment and selection policy which stated that all offer of employment were subject to satisfactory references, medical clearance, any other appropriate checks, such as asylum and immigration checks to ensure eligibility to work in the country. Disclosure and Barring Service (DBS) checks for clinical staff or for staff who may work on their own with patients and who may undertake chaperone duties with patients would also be carried out.

Where relevant, the practice made checks that members of staff were registered with their professional body and that GPs were on the performer's list. The practice manager made follow up checks to ensure that nurses continued to maintain their registration with the Nursing and Midwifery Council. Professional registrations of all professional staff were monitored and checked as required.

Safe staffing levels were maintained. Collectively four GPs provided a service to patients at Cornerstone Family Practice and at the branch practice in Audenshaw. The staffing team included two practice nurses, one of whom was based at the branch surgery. There was a practice manager, a deputy manager and six receptionists who collectively staffed both practices. The staff team were able to meet the needs of the patient population who were registered with them.

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

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. This ensured adequate staffing levels were maintained at all times.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patient, staff and visitors. These included checks of medicines and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Staff training was monitored and this ensured that staff had the rights skills to carry out their work. Staff had received training in fire safety and there was a nominated fire marshal for the practice.

Good

Are services safe?

We found checks were made to minimise risk and best practice was followed, for example in respect of medicines management. The practice had a system in place for reporting and monitoring significant events.

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

Practice meetings and integrated team meetings provided an opportunity for peer review and to discuss patients with complex care needs.

Arrangements to deal with emergencies and major incidents

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

The practice had arrangements in place to manage emergencies. Records showed that necessary staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The practice was located within a CCG managed building. The CCG had responsibility for all maintenance contracts including legionella testing for the building and fire evacuation drills.

Emergency medicines were available in a secure area of the practice and all staff knew of their location.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Staff and patients had access to telephone interpreter translation services and staff were familiar with how the service operated.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients on the palliative care register. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Patients with long term conditions were supported where possible to self-manage their conditions. The practice was committed to health promotion and improving patient's life style.

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

The practice held a register of patients who had a learning disability and we were told that these patients were called for annual health checks and there were 20 patients currently on the practice register.

The practice worked within the Gold Standard Framework for end of life care.

We saw from QOF that the practice had achieved 100% of child development checks and this was consistent with national guidelines.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. However this information was not collated to support the practice to carry out clinical audits. We saw limited evidence of clinical audits being completed on a regular basis by all GPs at the practice. Those that we reviewed did not sufficiently demonstrate an improvement to patient health and we did not see evidence of any two cycle audits having been completed at the practice.

The results of the National Quality and Outcomes Framework (QOF) 2014 showed that much more needed to be done to effectively manage patients' long term conditions. The practice achieved a total of 84.2% in its treatment of patients with chronic obstructive pulmonary disease, nine points less than the local average and 11 points less than the national average. The practice achieved a total of 68.8% for its treatment of patients with diabetes and 49.2% of outcomes had been achieved for patients with hypertension. We discussed these results with the practice. GPs told us they were aware these and had plans to implement a number of measures to improve outcomes for patients, these included recalling patients for reviews and promoting healthier lifestyles.

The practice achieved a total of 72.4% points of the National Quality and Outcomes Framework (QOF). The national Quality and Outcomes Framework (QOF) 2013/14 showed 100% of the outcomes had been achieved for patients with arterial fibrillation and a 100% for patients with asthma. This meant that there were a number of other areas were the practice was performing significantly better.

Good

Are services effective?

(for example, treatment is effective)

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).

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

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families including a review of patient's medicines and any other health or social care issues relevant to their care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We spoke with clinical and non-clinical staff and reviewed training records. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We saw that GPs had completed additional training, for example, in child sexual exploitation and domestic violence. We found that staff employed at the practice were qualified and competent to carry out their roles, However safeguarding training for GPs needed to be updated to ensure patient safety.

GPs kept evidence of their training and this was not shared with the practice manager who had an overview of training completed by all other staff employed at the practice.

Staff had access to training, the majority of which was completed through e-learning, some of the training completed included safeguarding children and adults, information governance and fire safety. Staff told us they were able to access training and received updates when required.

Staff appraisals were in place for both clinical and non-clinical staff.

All GPs took part in yearly appraisal that identified learning needs from which action plans were documented. GPs are required to be appraised annually and every five years undertake a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked with other agencies and professionals to provide continuity of care for patients and ensured care plans were in place for the most vulnerable patients. Multi-disciplinary meetings took place to discuss patients with complex care needs, including end of life care and child protection concerns as when required.

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

The practice was commissioned to provide a number of new enhanced services, for example, avoiding patients unplanned hospital admissions, dementia care and learning disability health checks. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

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

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

There was effective communication, information sharing and decision making about patients care across the practice and with external stakeholder, for example, with local authority safeguarding teams.

The practice used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Information received from other agencies, for example accident and emergency or hospital outpatient departments was read and actioned by GPs on the same day. Information was scanned onto electronic patient records in a timely manner. Systems were in place for managing blood results and recording information from outpatient's appointments.

Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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

The practice had signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

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

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

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

We found that majority of staff were aware of the Mental Capacity Act 2005, the Children's' Acts 1989 and 2004 and their duties in fulfilling it. GPs we spoke with understood the key parts of the legislation and were able to describe how they considered this in their practice and treatment of patients, for example best interest decisions and do not attempt resuscitation (DNACPR).

Health promotion and prevention

The practice was committed to promoting a healthy lifestyle for patients and this included providing information about services available at the practice for patients, for example, 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 (93.9%). We saw from the Quality and Outcomes framework (QOF) 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and there was a clear policy for following up non-attenders.

New patients were seen by a practice GP, when an assessment of their medical condition, including a review of their lifestyle, family medical history, smoking and alcohol activity was completed. Where it had been identified that a patient needed additional support, the practice was pro-active in offering additional help, for

Good

Are services effective?

(for example, treatment is effective)

example, diabetes support. Practice nurses managed and monitored patients with long term conditions, for example, Chronic Obstructive Pulmonary Disease (COPD) and diabetes.

Patients who smoked or who required assistance with weight management were provided with information and signposted to relevant clinics.

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

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

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

The practice's performance for cervical smear uptake was 68.5%, which was below the national average of 81.89%. The GPs were aware of their performance in this area and had plans to review procedures around follow up strategies for patients who did not attend.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The GP practice was made up of four GPs. Patients told they knew who their named GP was and they liked this. Patients told us they preferred to see the same GP for continuity of care, however this wasn't always possible as routine appointment to see the same GP were difficult to make.

We observed reception staff speaking to patients in a respectful way and we heard staff during telephone discussions also speaking in a courteous manner.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

Patients told us they had received excellent support following bereavement.

Patients told us they had used the open access surgery for emergency treatment and appreciated the availability of these appointments.

We spoke with five patients and reviewed 23 CQC comment cards received as part of our inspection. Feedback from patients was positive about the level of respect they received and dignity offered during consultations. Patients we spoke with told us they had enough time to discuss things fully with the GP and patients told us GPs listened to them. Patients told us they were fully involved in decisions made about any treatments recommended.

Facilities were available upon request should a patient with to speak in private. Patient telephone calls were received by staff in the reception area and calls to medical secretaries were made away from this area which maintained patient confidentiality.

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

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

Longer patient appointment times were available to patients who required extra time, for example, patients with mental health needs.

We looked at the results of the 2015 patient survey. This is an independent survey run on behalf of NHS England. The results showed that 93% of respondents said they had confidence and trust in the last GP they saw or spoke with and 97% of respondents said they had confidence and trust in the last nurse they saw or spoke with.

Care planning and involvement in decisions about care and treatment

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

We looked at the results of the 2015 patient survey. This is an independent survey run on behalf of NHS England. The results showed that 59% of patients stated that they always or almost always saw or spoke with their preferred GP, compared with 60% nationally.

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

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

GPs and practice nurses ensured patients were involved in making decisions concerning their care and treatment during appointments.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

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

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with monthly palliative care meetings. Bereaved patients could be referred to counselling service and information was displayed in the waiting area.

From the GP national survey 89% of respondents stated the last GP they saw or spoke to was good at listening to them, 90% say the last GP they saw or spoke to was good at giving them enough time and 96% had confidence and trust in the last GP they saw or spoke to.

The GP national survey reported 95% of respondents stated that the last nurse they saw or spoke with was good at treating them with care and concern.

Good

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

The practice GPs engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to discuss patients' needs and service improvements.

The practice worked with patients and families and worked collaboratively with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life. They did this most effectively through integrated working arrangements with health and social care partners.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and completing opportunistic screening and reviews.

The practice offered a range of specific clinics through the GP and nurse appointment system, including diabetes reviews and COPD, (chronic obstructive pulmonary disease**)** reviews.

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 telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice did not have an active patient participation group, despite attempts to develop one; however we were told that this was a priority for the practice in 2015.

We looked at the results of the 2015 patient survey. This is an independent survey run on behalf of NHS England. The results showed that 89% of respondents described their overall experience of the surgery as good in comparison with the local (CCG) average of 83%.

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

Tackling inequity and promoting equality

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

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

GPs provided telephone consultations and extended appointments were made available for any patient who required additional time.

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

The practice was accessible to patients with disabilities. A disabled toilet was available as were baby changing facilities and a hearing loop was located in the patient reception area.

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

Access to the service

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

Patients could access appointments by telephone, calling into the surgery and on line via the practice website. Patients were able to make appointments in advance. On the day emergency appointments were available by telephoning the practice. The practice operated open access surgeries every morning apart from Wednesday, between the hours of 8.45 and 10.15am.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There were plans to implement an extended hour's scheme between the hours of 6pm and 8pm and weekends. Working patients we spoke with told us they would welcome this service as it meant they would not need to take time off work to attend GP appointments.

We looked at the results of the 2015 patient survey. This is an independent survey run on behalf of NHS England. The results showed that 79% of respondents usually waited 15 minutes or less after their appointment time to be seen in comparison with the local (CCG) average of 56%.

From the CQC comment cards completed and speaking with patients we were told GP appointments were provided in 10 minute slots the majority of patients told us that it was relatively easy to get an appointment. Patients told us they would prefer to see the same GP and that there was a lot of patient demand for some GPs at the practice. Other patients told us they usually saw the same GP and they like the continuity of care this provided.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled complaints in the practice. The practice manager was mindful to respond and deal with patient's complaints as they arose in an attempt to avoid complaints escalating.

Information about the complaints process was provided in the patient practice leaflet and on the website. Information on how to make a complaint was displayed in the patient waiting area.

Patients we spoke with told us they knew how to make a complaint. They told us they felt comfortable about making a complaint and they were confident their complaint would be dealt with fairly. We saw complaints were logged and investigated by the practice manager who consulted with GPs and or nursing staff where relevant. Investigations addressed the original issues raised and action was taken to rectify problems. We saw that the provider responded to complaints' in a timely manner and had taken action to resolve their complaints.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality personalised care to patients and to promote good outcomes for patients. The practice had a strategy to develop personalised and accessible care to all patients; this included the development of extra appointments between the hours of 6pm and 8pm being made available to patients. The practice was part of the Northern Healthcare GPPO and there were plans to also provide extra appointments at weekends and to provide GP services from North Manchester General Hospital, separate to out of hour's provision.

Clinical and non-clinical staff we spoke with told us that the practice had gone through a lot of change over the past two years including a move to a new building in 2013 and changes to the makeup of the GP partnership. Staff we spoke with knew that the practice was committed to providing good quality primary care services for all patients, including the management of long term health conditions and supporting vulnerable patients. Staff told us they understood that this would ultimately benefit patients.

Staff were clear about their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and the practice staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at a selection of the policies that included mental capacity policy, child protection and vulnerable adults and infection control and saw these were up to date and reflected current guidance and legislation. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one GP was the lead for children's safeguarding. Staff we spoke with were clear about their roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice participated in the Quality and Outcomes Framework (QOF). This was used to monitor the quality of services in the practice. There were systems in place to record performance against QOF. Though this information was not used to conduct clinical audits.

The practice held business governance meetings, as well as clinical meetings. We looked at minutes from these meetings and observed that complaints and significant events were not a standing item on the agenda. However the practice made good use of integrated partnership meetings to review and plan patient care.

The practice worked closely with North Manchester Clinical Commissioning Group (CCG) and attended monthly locality meetings. The practice manager attended monthly practice manager forums organised through the CCG. These meetings provided an opportunity for shared learning and discussion of significant events with other practices in the North Manchester area.

Leadership, openness and transparency

There was an established management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

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

The GPs and the practice manager told us they valued the importance of obtaining and acting upon the views of patients and carers and recognised that this was an area that they needed to develop further.

In May 2015 the practice commissioned a private and independent patient questionnaire to gather feedback from patients on its performance. We saw a copy of the

Are services well-led?

Good

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

results of the survey which was very positive. Areas looked at included access to appointments, satisfaction with treatment and patients' views of staff. A total of 61 patients completed the survey. The survey showed 38 patients rated the GPs ability to listen to them as excellent. It showed 34 patients rated the GPs as excellent for showing them respect. In regard to the level of satisfaction with the opening hours 22 patients rated this as good and 19 patients reported that the ability to see a GP within 48 hours was good and 14 described this as poor. The practice had not yet had the opportunity to review the findings of the survey but there were plans to look at the findings in detail and consider what changes could be implemented for the benefit of patients.

The practice had also gathered patient feedback through the NHS friends and family test and at the time of our inspection was considering their response to a small sample of patient feedback.

The practice also considered and responded to patient feedback through the use of compliments and complaints.

The practice did not have a patient participation group. We saw a poster in the surgery promoting this and seeking patient involvement. The practice told us that historically they had a poor response but would consider what more they could do to encourage patient involvement.

Management lead through learning and 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 saw that appraisals had taken place for clinical and non-clinical staff over the last two years. A policy and procedure for staff appraisals was in place and a number of other staff appraisals had been scheduled. Staff told us that the practice was very supportive of training and development opportunities. Training included infection control, basic life support and safeguarding.

In February 2015 the practice was approved by Health Education England to be a GP and nurse training practice and there were plans to begin training in September 2015. Both GPs and the practice manager were mindful of the importance of ensuring an induction programme was in place to support GP trainees.