Dr Seabrook & partners

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Dr Seabrook and Partners on 19 January 2017. Overall the practice is rated as Good.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Feedback from patients about their care was consistently and strongly positive. Patients were extremely positive about the practice's named and usual GP systems.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example the practice was working across the locality and with neighbourhood practices to input into future changes in local NHS service delivery.
- 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 patient reference group (PRG). For example a new telephone system was implemented after patient and Patient Reference Group (PRG) feedback
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had 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.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

Summary of findings

We saw three areas of outstanding practice:

- The practice employed a Proactive Care Nurse. This role was solely to maintain current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result. Staff were also assisted in the homes via training and support sessions on various conditions and their treatments.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction.
- The practice provided a 24hr BP monitoring service to its own patients and those in locality practices. The service provided 15 appointments per week and had been used by over 1,100 patients, 70% of which were from other practices.

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.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Recruitment files contained all the required employment information.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice employed a Proactive Care Nurse. This role was solely to maintain current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result. Staff were also assisted in the homes via training and support sessions on various conditions and their treatments.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction.
- A range of clinical audits were undertaken and these demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 88% and 85% respectively.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients we spoke with, who had individualised care plans, told us they felt fully informed and included in all decisions about their care.
- Information for patients about the services available was easy to understand and accessible.

We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice offered extended services to patients from other local practices.
- The practice had implemented a person centred primary care diabetic service for those patients historically hard to reach and with multiple risk factors.
- Patients said they found it easy to make an appointment with a named GP and usual GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

- 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 evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice employed a Proactive Care Nurse. This role was solely to maintain current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result. Staff were also assisted in the homes via training and support sessions on various conditions and their treatments.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction.

Are services well-led?

Good 

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- The whole practice demonstrated strong cohesive team work.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient reference group was active.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels.

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.

- All patients over 75 years had a named GP.
- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The proactive care nurse maintained current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority via the additional work undertaken by the proactive care nurse.
- 80% of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months (01/04/2015 to 31/03/2016) which was comparable with the CCG and national average of 80% and 78% respectively.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 86% which was comparable with the CCG and national average of 85% and 80% respectively.
- More flexible and longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- These patients were identified on a priority patient system to expedite appointments or home visits.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple

clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction.

- A recent audit for the management of patients on warfarin (a blood thinning medication) had resulted in the practice developing an INR (international normalized ratio or blood clotting times) calculator to establish the optimum treatment times and dosage and was currently undergoing an external quality peer review. This had resulted in a more effective treatment regime and treatments that could be provided "at point of contact" care at the practice rather than attending hospital appointments.
- The proactive care nurse maintained current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years (01/04/2011 to 31/03/2016) was 81% which was similar to the CCG and national average of 82% and 81% respectively.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Flexible access was available with an urgent Monday morning clinic. Early extended hours appointments were available three days per week in addition to a monthly Saturday morning clinic.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice identified vulnerable patients on a priority patient list.
- The proactive care nurse maintained current care plans and support.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 80% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG and national average of 85% and 84% respectively.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive,

agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 94% which again was comparable to the CCG and national average of 92% and 89% respectively.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia and offered reviews every six months.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia, with practice screening and lead GPs.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 242 survey forms were distributed and 116 were returned. This represented a response rate of 48% and 1% of the practice's patient list.

- 80% of patients found it easy to get through to this practice by phone compared to the CCG and national average of 79% and 73% respectively.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG and national average of 80% and 76% respectively.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG and national average of 89% and 85% respectively.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG and national average of 84% and 79% respectively.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards which were all extremely positive about the standard of care and treatment received.

We spoke with five patients during the inspection. All five patients said they were extremely satisfied with the care they received and thought staff were approachable, committed and caring. Patients explained how the support and proactive interventions by the practice, meant that patients had been able to be treated at home, even when their complex medical conditions were acutely distressing.

Areas for improvement

Outstanding practice

- The practice employed a Proactive Care Nurse. This role was solely to maintain current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result. Staff were also assisted in the homes via training and support sessions on various conditions and their treatments.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction.

Dr Seabrook & partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Dr Seabrook & partners

Dr Seabrook and Partners is located at Cheadle Hulme Health Centre, Smithy Green, Hulme Hall Road, Cheadle, SK8 6LU. There is also a branch surgery at Bridge House Medical Centre, 11 Ladybridge Road, Cheadle Hulme SK8 5LL. We visited both surgeries during this inspection.

The practice has 12,571 registered patients and they can access services at either surgery. The practice provides primary care under a Personal Medical Services Contract (PMS) and is part of NHS Stockport Clinical Commissioning Group (CCG).

The practice provides a range of enhanced services to its own registered patients as well as patients in several practices in the locality.

Dr Seabrook and Partners are located in an area of considerable affluence but with some pockets of deprivation. Information published by Public Health England rates the level of deprivation within the practice population as 10 on a scale of one to ten. Level one represents the highest areas of deprivation and ten as the lowest.

There are 54% of patients with a long term health condition, which is the same as both the CCG and the national average. The practice also has a higher percentage of patients over 75years at 11% compared with 8.7% CCG and 7.8% national average.

The practice staff consists of seven GP partners, three female and four male. Clinical staff consist of two Advanced Nurse Practitioners, one who is a Diabetic Nurse Specialist, one Specialist Proactive Care Nurse, three practices nurses and four healthcare assistants. The practice is supported by a senior practice manager, a practice manager and a number of administration and reception staff.

The role of senior practice manager has allowed the practice manager to take over the day to day responsibility of the practice, whilst the senior practice manager is focusing on the future NHS agendas such as Devo Manchester and NHS Forward View, and how this will impact on the practice, the locality and neighbourhood.

It is a well-established training practice and supports GPs in training as well as Doctors at foundation level and medical students.

The practice at Cheadle Hulme Health Centre is open between 7.30am and 6.30pm Monday to Friday. Appointment times are from 7.30am to 11.15am and 3pm to 6pm Monday, Wednesday and Thursday and 8.30am to 12.15pm and 3pm to 6pm each Tuesday and Friday. Extended hours surgeries are offered each month when a Saturday morning surgery is available.

Bridge House is open from 9am until 12.30 pm and 1.30pm until 5.30pm each weekday.

Each Monday morning there is also an emergency surgery held at Bridge House from 7.30am as well as additional surgeries before and after a Bank Holiday weekend.

Detailed findings

When the practice is closed patients are asked to contact NHS 111 service.

Why we carried out this inspection

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. There was no concerning information shared.

We carried out an announced visit on 19 January 2017.

During our visit we spoke with a range of staff including:

- All GP partners
- Advanced Nurse practitioner, Proactive Care Nurse and Practice Nurses
- Health Care Assistants
- Practice Manager
- Administration staff.
- We spoke with five patients that used the service, two of which were members of the Patient Reference Group.
- We observed how staff interacted with patients.
- We reviewed 39 comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The significant event form was also used as a reflective learning tool which was discussed at significant event meetings, held every six weeks and for appraisal purposes.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, when a vaccination was given in error, there was a clear evidence trail detailing the actions taken to avoid a reoccurrence.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP and deputy, with an administration member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3, as were all nursing staff.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The advanced nurse practitioner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. The advanced nurse practitioners had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received appropriate mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to

Good

Are services safe?

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Minor improvements were needed to standardise staff files.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were effective procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty and to provide cover for holiday and sick leave.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies were also kept on the practices managers' mobile phone.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had well established and comprehensive systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available,with an exception reporting rate of 6.5% for the clinical domains (compared to the local average of 10.7% and national average of 9.8%) (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was similar to the national average. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 90% which was above the clinical commissioning group (CCG) and national average of 85% and 80% respectively.
- Performance for mental health related indicators was similar to the national average. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months (01/04/2015 to 31/03/2016) was 94% which was comparable to the CCG and national average of 92% and 89% respectively.

There was evidence of quality improvement including clinical audit.

- There had been a number clinical audits completed in the last two years, with each GP completing a programme of audits. Six of these were completed audits where the improvements made were implemented and monitored and reaudited.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, a recent audit for the management of patients on warfarin (a blood thinning medication) had resulted in the practice developing an INR (international normalized ratio or blood clotting times) calculator to establish the optimum monitoring times and dosage and was currently undergoing an external quality peer review. This had resulted in a more effective treatment regime and treatments that could be provided "at point of contact" care at the practice rather than attending hospital appointments.

Information about patients' outcomes was used to make improvements such as:

- The advanced nurse diabetic specialist and the GP diabetic specialist had implemented a primary care complex diabetic clinic to manage the most hard to reach patients and those with poorly controlled, complex diabetes with multiple risk factors . The programme provided interventions that would normally take place in secondary care This intensive individualised programme resulted in less hospital admissions in this cohort of patients and very high patient satisfaction in the overall management of this long term condition.
- Each patient was given an individualised care programme; containing time bound individual goals and agreed actions to achieve those goals. This varied from reduction in weight, cholesterol levels and blood pressure. Audit results in 2016 had shown consistently improved results in blood pressure readings, cholesterol

Good

Are services effective?

(for example, treatment is effective)

levels and BMI (body mass index) readings. For example 26 patients saw their HBA1c reduce by an average of 16.84% and all but one patient had a reduction of cholesterol levels.

- In addition to supporting the intensive patient centred specialist service aimed at the most complex diabetics, the role of the diabetic specialist nurse (DSN) allowed the practice to restructure and co-ordinate the diabetes care provided to all patients on the diabetes register (591) based on patient need.
- The practice had implemented the role of proactive care nurse. The aim of this role was to implement and maintain current care plans for patients with long term conditions, patients with multiple complex needs, house bound and those patients who lived in nursing or residential care homes. Training and support was also provided to the care and nursing homes by the proactive care nurse.
- Minor surgery was undertaken at the practice. 235 patients benefitted from these procedures in 2016 avoiding the need to attend a hospital appointment.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers and those at risk of developing a long-term condition.
- Smoking cessation sessions were led by a trained health care assistant.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 82% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 94% and five year olds from 87% to 91%.

The practice provided a comprehensive flu and pneumococcal immunisation programme for its patient population. In 2016, the practice provided flu vaccination clinics on 5 consecutive Saturdays, during early evenings, through home visits as well as appointments throughout the normal working week. Overall, 3,860 (30%) of practice patients received a flu vaccination this season (3,355 have been given by the practice). In addition practice records indicate that 80% of the patients over the age of 65 had received a pneumococcal vaccination

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Disposable curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. These were replaced as date recorded.
- We noted that consultation and treatment room doors were closed during consultations and all had coded access; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice offered continuity of personalised care through a personal list system from a usual GP

All of the 39 patient Care Quality Commission comment cards we received were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. GPs, nurses and reception staff were individually named as going above and beyond what was expected. Patients we spoke with described many occasions when staff had provided exceptional care, particularly to dependants that had complex multiple needs and were in crisis. This had resulted in care being given at home rather than requiring hospital admissions. Patients with complex long term conditions described staff that took their time to explain conditions and treatments and above all supported patients to improve their own health and well-being.

We spoke with two members of the patient reference group (PRG). They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above or comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 88% and 85% respectively.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients 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 available to them. Patient feedback from the comment cards we received was also extremely positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above or comparable with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.

Good

Are services caring?

- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format. Information on the practice website was also available in other languages.
- A sign language interpreter was also available, with longer appointments identified.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. There was a carer's register and the practice had identified 195 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. The practice proactively offered health checks and vaccinations, with 68% of carers taking up flu vaccinations.

Staff told us that if families had suffered bereavement, the family were contacted by their named GP, with home visits offered. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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.

- Extended hours were available three mornings per week and on one Saturday per month.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A Monday drop in clinic was managed by four GPs and effectively offered open access for new conditions or acute acerbations of existing conditions. Appointments for the Monday Morning clinic became available to book online on the preceding Saturday & Sunday each week.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- Patients with more complex conditions were identified on a priority patient system to expedite appointments or home visits.
- The practice employed a Proactive Care Nurse. This role was solely to maintain current care plans for all registered patients with complex multiple conditions and those in care and nursing homes. Weekly visits were undertaken to the homes and admissions to hospital had reduced as a result. Staff were also assisted in the homes via training and support sessions on various conditions and their treatments.
- The practice had implemented a primary care specialist diabetes service which gave intense patient centred care for those patients with regular uncontrolled diabetes, multiple clinical risk factors and who were historically hard to engage with conventional treatments in the hospital settings. Each had personalised care plans and goals agreed. Audits undertaken had seen a marked reduction in multiple risk factors, such as cholesterol, blood pressure levels and Body Mass Index (BMI) and high patient compliance and satisfaction. For example 26 patients saw their HBA1c reduce by an average of 16.84% and all but one patient had a reduction of cholesterol levels.
- A recent audit for the management of patients on warfarin (a blood thinning medication) had resulted in the practice developing an INR (international normalized ratio or blood clotting times) calculator to establish the optimum treatment times and dosage and was currently undergoing an external quality peer review. This had resulted in a more effective treatment regime and treatments that could be provided "at point of contact" care at the practice rather than attending hospital appointments.
- The practice provided a 24hr BP monitoring service to its own patients and those in locality practices. The service provided 15 appointments per week and had been used by over 1,100 patients, 70% of which were from other practices.

Access to the service

The practice at Cheadle Hulme Health Centre is open between 7.30am and 6.30pm Monday to Friday. Appointment times are from 7.30am to 11.15am and 3pm to 6pm Monday, Wednesday and Thursday and 8.30am to 12.15pm and 3pm to 6pm each Tuesday and Friday. Extended hours surgeries are offered each month when a Saturday morning surgery is available.

Bridge House is open for appointments from 9am until 12.30 pm and 1.30pm until 5.30pm each weekday.

Each Monday morning there is also an emergency surgery held at Bridge House from 7.30am as well as additional surgeries before and after a Bank Holiday weekend.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 70% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 78%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 79% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and national average of 79%.

People told us on the day of the inspection that they were able to get appointments when they needed them. They said that they had named or usual GPs so that continuity of care was provided.

We saw on the day of inspection that appointments were available on the day at both the main and branch surgeries, with some routine appointments available in seven days.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Listening and learning from concerns and complaints

The practice had an effective 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 policy required a minor addition to include the acknowledgement letter, which was sent but omitted from the policy guidance

- There was a designated responsible person who handled all complaints in the practice.
- We saw that an information poster was available to help patients understand the complaints system

We looked at 10 complaints received in the last 12 months and found these were dealt with in a timely way and with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, a complaint had been received when information was not relayed to the patient, should the condition deteriorate. As a result this was identified as a training need for reception staff and this was completed at a staff training event.

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 care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice was liaising with other practices, the neighbourhood, the clinical commissioning group (CCG) and Local Medical Committee (LMC) to shape services and improve patient care

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. It was clear that the practice had a strong cohesive team.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days/ events were held.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had regular education and training events.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the virtual patient reference group (PRG) and through surveys and complaints received. Although the PRG had not met regularly, they had frequent communication with the practice. They carried out patient surveys and submitted proposals for

Are services well-led?

Good

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

improvements to the practice management team. For example, following several complaints and discussion with the PRG a new telephone system was implemented.

- The practice had gathered feedback from staff through staff away days/events and generally through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

Nursing staff were supported to attend courses and additional academic studies.

It was a well-established training practice and supported GPs in training as well as Doctors at foundation level and medical students.

The role of senior practice manager has allowed the practice manager to take over the day to day responsibility of the practice, whilst the senior practice manager is focusing on the future NHS agendas such as Devo Manchester and NHS Forward View, and how this will impact on the practice, the locality and neighbourhood.

This year the practice was recognised for its contribution to medical research in gaining the Research Ready RCGP Accreditation and by being nominated for a Greater Manchester Research Network Award for the Best Community Research Contribution.