

Brinnington Surgery

Quality Report

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Date of inspection visit: 6 October 2016

Date of publication: 22/11/2016

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

Ratings

Overall rating for this service

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	8
What people who use the service say	12
Areas for improvement	12
Outstanding practice	12

Detailed findings from this inspection

Our inspection team	14
Background to Brinnington Surgery	14
Why we carried out this inspection	14
How we carried out this inspection	14
Detailed findings	16

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brinnington Surgery on 6 October 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had a strong vision, which put quality, effective care and treatment as its top priority. The partnership was structured with distinct roles and responsibilities, utilising the experience and skills of partners to the full. As a result, all business and clinical matters were delivered effectively at the practice.
- The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

- Patients described the GP practice as excellent; staff were described as caring and professional.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the appointment system following a review in 2015 was changed to provide a minimum of 12 minutes per appointment and schedule a GP telephone appointment for every fifth appointment.
- 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.

We saw some areas of outstanding practice including:

- The practice was committed to safeguarding children and vulnerable adults. Safeguarding referrals were

Summary of findings

reviewed as significant events and learning from these shared within the Clinical Commissioning Group (CCG) and the local NHS trust. For example, one child safeguarding incident resulted in changes to the practice's postnatal baby check template to include more information about the family situation. The adapted template was shared with the CCG. The changes to the postnatal template enabled the practice to identify two incidents where young children were considered at potential risk and safeguarding procedures were implemented.

- The practice sent out 'case finding' questionnaires to patients over 65 years to identify any unmet health care needs.
- The practice had a designated 'Speaking Up Guardian' who was independent of the practice partnership. This provided staff with someone they could raise concerns to under the practice whistleblowing policy.

The areas where the provider should make improvement are:

- Implement a system to ensure patient medicine reviews that are undertaken are recorded in the patient records as being completed.
- To support the current risk assessment and to further mitigate any potential risk to patients, staff undertaking the role of chaperone should have a Disclosure and Barring Service (DBS) check.
- Extend patient participation at the practice by implementing ways for patients who do not have access to the internet or social media applications to contribute to the development of the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events. The practice fostered a culture of learning. For example all clinical staff and trainee GPs were encouraged to present significant events they identified at the monthly clinical meeting so learning and improvements were shared.
- Information about safety was highly valued and was used to promote learning and improvement.
- 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.
- Safeguarding of children and vulnerable patients was prioritised with strong leadership, high levels of staff training and a committed team. Support to implement and respond to safeguarding concerns was provided to other practices within the Stockport locality.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. However ensuring Disclosure and Barring Service (DBS) checks for all staff undertaking the role of chaperone were in place would improve the mitigation of potential risk to patients.

Good



Are services effective?

The practice is rated as outstanding for providing effective services.

- Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Staff assessed needs and delivered care in line with current evidence based guidance.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. For example, the GP clinical leads undertook clinical audits for their area of speciality and there was evidence that the practice took action to ensure optimum care and treatment was provided to patients.

Outstanding



Summary of findings

- The practice was aware of the challenges their patients faced living in a community with high levels of deprivation and proactively brought supportive services in house in a bid to improve patient health and wellbeing.
- Data showed that the practice was performing at a consistent level and was comparable to practices within the Clinical Commissioning Group and England.
- A comprehensive clinical audit programme was in place to review and promote quality improvement. The practice benchmarked themselves and took action to improve when shortfalls in performance were identified.
- The practice was committed to training and developing the whole staff team.

Are services caring?

The practice is rated as good for providing caring services.

- We observed a strong patient-centred culture. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Discussions with staff demonstrated that there was a strong commitment to providing patients with as much support as possible to access health care locally.
- The practice took action to ensure patients had access to information and guidance to support them with both health and social care problems.
- Information for patients about the services available was easy to understand and accessible.
- Data from the national GP patient survey showed patients rated the practice at a comparable level to other practices in the locality. However, patients we spoke with and feedback comment cards praised the whole staff team.

Good



Are services responsive to people's needs?

The practice is rated as outstanding 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 (CCG) to secure improvements to services where these were identified. For example the practice had obtained funding to employ a part time practice based pharmacist and a part time mental health care navigator to provide advice and guidance to patients to promote mental health wellbeing.

Outstanding



Summary of findings

- The practice monitored GP appointment availability to ensure there were sufficient appointments available to meet demand. The practice manager reviewed patient feedback about access to appointments and adapted staffing levels and appointment times to improve access. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice provided GP medical cover to residents living in five local care homes, two supported living tenancies for people with a learning disability and 22 patients requiring intermediate care. Each care home and service was allocated a dedicated GP who carried planned weekly visits to each home.
- Each practice nurse was also allocated a specific care home and worked closely with care home staff to ensure patients received the right medical care and support.
- The practice employed a staff member specifically to support patients with their mental health wellbeing and a local charity attended the practice on a weekly basis to offer support and signposting to patients with a range of social issues.
- The practice facilitated and supported the provision of additional medical services from the practice to enable patients to access these. For example, a consultant psychiatrist worked from the practice one day per month, a weekly shared care drug misuse clinic was held and a consultant led ADHD clinic operated every second month at the practice.
- The practice nursing team visited housebound patients with a long term health condition and those identified at risk of unplanned admission to hospital at home. They carried out an assessment and recorded a care plan with the patient and or their carer.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well led.

- The practice had a clear vision with 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 benefited from strong leadership. High standards were promoted and owned by all practice staff and teams worked together across all roles.

Good



Summary of findings

- The practice staff team were active in the clinical commissioning group (CCG) and the wider primary medical service provision for Stockport. For example, GP partners were CCG leads for Safeguarding and IT. One partner was the CCG locality chair and two partners (one GP and the practice manager) were members of GP Federation (Viaduct) leadership council for the Tame Valley neighbourhood.
- Governance and performance management arrangements were proactively reviewed
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. One salaried GP was the practice's 'Speaking Up Guardian' and provided a point of contact for staff who may wish to implement the whistleblowing policy.
- The practice did not have a patient participation group. However, for patients with internet access, the practice did have a Friends of Brinnington Surgery Facebook page, which the practice stated was a virtual patient reference group. This was accessible once the patient had been accepted as a friend by the Brinnington Surgery Facebook account.
- 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

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 in its population. The practice routinely visited all housebound patients to review their health care needs. Care plans were place for all these patients.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Case finding questionnaires were sent to patients aged over 65 to help identify any unmet needs.
- GPs and practice nurses were allocated a specific care home and carried out regular planned visits to each home. The practice met every second month with the care home managers at meetings to discuss a range of issues.
- Care plans were in place for those patients considered at risk of unplanned admission to hospital.
- Palliative care and neighbourhood multi-disciplinary meeting were held regularly with community health care professionals. Patients on the palliative care register had care plans in place.
- In 2015/16 influenza immunisation uptake was 80% compared with the CCG average of 75%.
- The practice has a designated cancer champion who has tried to encourage patients to attend breast screening appointments or complete bowel screening kits.
- The practice was implementing a programme of patient pulse checks for those over 65 years of age to identify those with an irregular pulse (atrial fibrillation).

Good



People with long term conditions

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.
- The practice performed better than the national average in all five of the diabetes indicators outlined in the Quality of Outcomes Framework (QOF). The practice carried out insulin initiation and they also initiated GLP-1 (glucagon-like peptide 1) treatments which were normally initiated within a hospital setting.

Outstanding



Summary of findings

- A recent drive to review patients at risk of developing pre-diabetes identified additional 250 patients as being at risk. The practice consulted with Public Health England to bring the pre diabetes awareness and education course into the local community (DESMOND -Diabetes Education and Self Management for Ongoing and Diagnosed). The first meeting was arranged for the 1 December 2016.
- Longer appointments and home visits were available when needed. All housebound patients with a long term condition were visited regularly to ensure the appropriate screening was undertaken. All these patients also had a self-management or an advanced care plan in place.
- All 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.

Families, children and young people

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.
- Safeguarding children and young people was a priority and the practice was proactive in identifying people at potential risk. Safeguarding referrals were reviewed as significant events to identify learning and improvements. This had led to improvements in the eight week postnatal baby check template, which was shared with the Clinical Commissioning Group.
- Immunisation rates were comparable to the locality 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 practice provided a full range contraceptive services including long-acting reversible contraception, such as coils and implants.
- Quality and Outcome Framework (QOF) 2014/15 data showed that practice performance reflected the Clinical Commissioning Group and the England averages. For example, 75% of patients with asthma, on the register, had received an asthma review in the preceding 12 months (CCG 76% and national data 75%).

Good



Summary of findings

- The practice's uptake for the cervical screening programme was 82%, and reflected the CCG and the England average,
- 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 and health visitors with regular meetings and electronic contact. There was a weekly antenatal clinic at the practice.
- A consultant led, attention deficit hyperactivity disorder (ADHD) clinic was held once every two months from the practice enabling patients to access the service without having to travel.

Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone consultations were available each day and extended hours for GP, practice nurse and assistant practitioner appointments were available on a Monday evening until 7.30pm and Friday mornings from 7am.
- 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.

Good



People whose circumstances may make them vulnerable

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

- The staff team were well trained in recognising and responding to patients at risk of abuse.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. Care plans were recorded for patients with a learning disability.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- One GP partner supervised a weekly shared care drug misuse clinic in the practice.
- The practice facilitated in house supportive initiatives for the practice's patient population. This included weekly visits by

Outstanding



Summary of findings

Healthy Stockport, which provided an open door drop in service at the practice where patients could get advice and signposting to support for social issues, lifestyle choices including diet, alcohol and drugs use.

- Telephone and face-to-face language and sign language interpreters were provided as required.

People experiencing poor mental health (including people with dementia)

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

- The practice provided in house a Mental HealthCare Navigator to provide guidance and support to patients with low-level depression and anxiety.
- The practice facilitated and supported the provision of additional medical services for example a consultant psychiatrist worked from the practice one day per month.
- The practice carried out six monthly dementia reviews and these patients had care plans in place. Data from 2014/15 showed that 91% of patients had had a face to face review compared to the average of 87% for the Clinical Commissioning Group (CCG) and England average of 84%.
- Data from 2014/15 showed 87% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was slightly below the CCG and England average of 90%.
- 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.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line or comparable to local and national averages. A total of 371 survey forms were distributed, and 75 were returned. This was a response rate of 20% and represented approximately 0.23% of the practice's patient list.

- 85% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 79% and the national average of 73%.
- 82% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and the national average of 85%.
- 91% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and the national average of 85%.
- 87% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 83% and the national average of 78%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards, 27 of which were positive about the standard of GP care received. Patients described the service as good, staff were helpful and

respectful and the GP was described as caring and responsive. Three comment cards referred to specific issues they had experienced. We spoke with one patient during the inspection and they were complimentary about the service they received and compared this positively to other local practices they had been registered with previously. The day after the inspection we spoke with three patients by telephone. They told us of the specific person centred support they had received. A couple of patients mentioned that the appointments did run late but accepted that this was because GPs never rushed and listened to them during their consultations.

The practice did not have a patient participation group (PPG). The practice told us they had really struggled to gain any interest or support for a PPG. However, for patients with internet access, the practice did have a Friends of Brinnington Surgery Facebook page, which the practice stated was a virtual reference group. This was accessible once the patient had been accepted as a friend by the Brinnington Surgery Facebook account. This was used to share information and seek and receive patient feedback. Two patients we spoke with confirmed they found the Friends of Brinnington Surgery Facebook page to be useful.

The practice analysed the results of the GP patient survey, monitoring the feedback from patients and timetabling additional reviews and evaluations.

Areas for improvement

Action the service SHOULD take to improve

- Implement a system to ensure patient medicine reviews that are undertaken are recorded in the patient records as being completed.
- To support the current risk assessment and to further mitigate any potential risk to patients, staff undertaking the role of chaperone should have a Disclosure and Barring Service (DBS) check.
- Extend patient participation at the practice by implementing ways for patients who do not have access to the internet or social media applications to contribute to the development of the practice.

Outstanding practice

We saw some areas of outstanding practice including:

Summary of findings

- The practice was committed to safeguarding children and vulnerable adults. Safeguarding referrals were reviewed as significant events and learning from these shared within the Clinical Commissioning Group (CCG) and the local NHS trust. For example, one child safeguarding incident resulted in changes to the practice's postnatal baby check template to include more information about the family situation. The adapted template was shared with the CCG. The changes to the postnatal template enabled the practice to identify two incidents where young children were considered at potential risk and safeguarding procedures were implemented.
- The practice sent out 'case finding' questionnaires to patients over 65 years to identify any unmet health care needs.
- The practice had a designated 'Speaking Up Guardian' who was independent of the practice partnership. This provided staff with someone they could raise concerns to under the practice whistleblowing policy.

Brinnington Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Brinnington Surgery

Brinnington Surgery is part of the NHS Stockport Clinical Commissioning Group (CCG). Services are provided under a personal medical services (PMS) contract with NHS England. The practice told us that they had 8759 patients on their register.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male life expectancy is 74 years and female life expectancy is 78 years in the practice geographical area, which is significantly below the England and CCG averages of 79 years and 83 years respectively.

The practice's patient population for the under 18 years of age at 26% is much larger than the local and England average of 20%. Further, the practice is located in an area that has a patient population with a higher rate of long standing health conditions (59% compared to 53% locally and 54% nationally) and there is a significantly higher rate of unemployment at 19% compared to 5% locally and nationally.

The practice is located within a NHS property service health centre. The district nursing and health visitors' teams, podiatry, two dental practices and one independent

pharmacy are also located in the building. The community midwives team run a weekly antenatal clinic at the practice and a blood anti-coagulation clinic is held at the centre each week. The building provides 13 consultations rooms all with ground level access, which is suitable for people with mobility issues. Car parking is available at the practice and a range of local shops are available close by.

The practice is a partnership between six GPs (four male and two female) and one non clinical partner who is the practice manager. Six partners are registered with CQC and the seventh partner has attempted to complete their application for inclusion on the CQC register. In addition to the partners, the practice employs four salaried GPs (three female and one male), four practice nurses, two assistant practitioners, a pharmacist, a mental health care navigator and a number of reception and admin staff. The practice is a GP training practice.

The practice is open between 8am to 6.30pm Monday to Friday, with extended hours for GP, practice nurse and assistant practitioner appointments on a Monday evening until 7.30pm and Friday mornings from 7am. Appointments were available in the mornings Mondays to Thursday from 8.30 am to 12pm and Fridays from 7.10am to 12pm . Afternoon appointments were available Mondays from 2pm until 7.30pm and from 2pm until 6pm Tuesday to Friday.

When the practice is closed patients are asked to contact NHS 111 for Out of Hours GP care.

The practice provides online access that allows patients to order prescriptions and request and cancel an appointment.

Detailed findings

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

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 6 October 2016.

During our visit:

- We spoke with a range of staff including three GP partners, one salaried GP, the practice manager, two practice nurses, one assistant practitioner, reception and admin staff, including the practice medicines coordinator and the practice cancer champion.
- We spoke with one patient on the inspection day and three patients on the telephone the day after the inspection visit.

- We observed how reception staff communicated with patients.
- We reviewed a range of records including staff records and environmental records.
- We reviewed an anonymised sample of the personal care or treatment records of patients.

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 were provided for specific groups of people and what good care looked 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).

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

Are services safe?

Our findings

Safe track record and learning

There was a comprehensive and 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 practice manager logged incidents and significant events. Staff confirmed there was an open, safe environment to raise issues and they provided examples of the different incidents they either had been involved in or were aware of.
- A policy was in place to support 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 practice provided an example whereby they had implemented their duty of candour policy.
- The practice held monthly clinical meeting whereby a review of significant events was a standing agenda item. The clinical meeting minutes for August 2016 detailed the presentation of the analysis of two significant events. These were presented by different GPs using different formats. For example, one GP described the situation, the actions and outcome of a request for a prescription for medicine for a patient who was out of this country for more than three months. Learning points from this incident was that the community mental health team were notified that patients could not be prescribed medicine whilst outside this country. The second investigation and outcome of a significant event was delivered as power point presentation and it was about a patient with dizziness, which eventually was diagnosed as cancer. The learning from this was to raise GPs awareness of a number of different symptoms that could be indicators requiring further investigation.
- The summary log of significant events showed that detailed analysis and or investigations had been carried out, learning points identified with actions agreed and a review to see if the agreed actions had been implemented. All clinical staff, including practice nurses and trainee GPs were encouraged to present significant

events they identified at the monthly clinical meeting so learning and improvements were shared. Some complaints received by the practice were investigated and analysed as a significant event.

- Non clinical significant events were shared at the monthly administrative team meetings.
- Changes in practice following significant event investigations included ensuring there was always sufficient oxygen available at the practice; a review of systems to ensure safe prescribing for patients accommodated on an intermediate care unit and ensuring alternative IT equipment was available in the event of the loss of IT.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

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.
- One GP partner was the lead member of staff for safeguarding and they were trained to level 4 in child safeguarding leadership. (The usual level of training for GPs in child safeguarding is level 3). The GP was also the Clinical Commissioning Group (CCG) named GP for safeguarding children and vulnerable adults and they were a member of the national Royal College of General Practitioners (RCGP) safeguarding forum. The practice manager was the safeguarding deputy. All other GPs, practice nursing team and admin team were trained to the appropriate level, for example GPs were trained to level 3 in children's safeguarding and practice nurse to level 2.
- The practice held two half-day away days each year for the whole staff team. Staff spoken with told us that at the away day in July 2016 several aspects of safeguarding was discussed including sexual exploitation, female genital mutilation (FGM), the Mental

Are services safe?

Capacity Act and Deprivation of Liberty Safeguards (DoLS) and Prevent and the anti-terrorism strategy. (Prevent is part of the government strategy which aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves). The GP lead for safeguarding had completed training (train the trainer) in Prevent and they were awaiting their registration PIN number to roll out this training.

- The practice's annual development plan for 2016-17 included a section on safeguarding children and adults. This identified actions to be implemented with timescales, including a session at the staff away day 'What makes somebody vulnerable' (completed) and staff training to level 3 child safeguarding and part two adult safeguarding training for practice nurses, locums and new GPs (completion date March 2017).
- In addition, the practice had carried out a NHS England audit of the safeguarding practices implemented for children and adults. This identified two small areas as requiring additional work. These included a designated safeguarding deputy lead, (one of the practice nurses confirmed they had been asked to undertake this) and the completion of level 3 children's safeguarding training before March 2017.
- Staff spoken with across all roles at the practice were very aware of their responsibility to report any concerns to the GP. Children, families and vulnerable adults identified as at risk or with safeguarding protection plan in place, were flagged up on the practice's electronic patient record system. One practice nurse told us of a referral they had made for a vulnerable adult with a learning disability.
- Safeguarding concerns were also reviewed as significant events to identify how the practice could improve their procedures and protocols to improve the safety of patient outcomes. For example, analysis of the management by an emergency department of bruising on a child resulted in the GP practice adapting their eight week postnatal baby check template to ensure as much information about the family situation, including the baby's father and males living in the family home was obtained. The adapted template was shared with the CCG. As a result of the additions to the eight week baby check two children's safeguarding referrals had been made. The outcome of the analysis of another significant event relating to the care and treatment of a sexually active teenager identified that safeguarding risks such as consent, grooming and sexual exploitation must always be considered.
- The lead GP for safeguarding met every second month with the health visitors, schools nurses and district nurses to discuss patients considered at risk or with a safeguarding plan in place. In addition the GP practice facilitated care home manager meetings with the care home managers from the five care homes the practice supported. Safeguarding vulnerable patients was discussed at these meetings.
- Notices displayed at the practice advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role, however not all non clinical staff had a Disclosure and Barring Service (DBS) check in place. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A risk assessment was in place that stated that staff undertaking the role of chaperone were always under the direct supervision of a clinician, reducing potential risks to the patient. However, a DBS check for all staff who undertook the role of chaperone would further mitigate the potential risks to patients.
- The practice was maintained and cleaned by the NHS Property Services. The practice monitored the standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The infection control clinical lead 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. For example, an infection control audit was undertaken in August 2016 by the local authority infection prevention nurse. This identified one area for improvement in relation to segregation of sharps waste. It was evident from our observations, and team meeting minutes that this area had been addressed.
- 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

Are services safe?

medicines. The practice had recently employed a part time pharmacist to help support the practice to improve the quality of prescribing, to review patient hospital discharge prescriptions and to undertake some medicine reviews. The practice also had a medicines co-ordinator who carried out regular medicines audits, with the support of the local 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. One of the nurses had qualified as a non medical prescriber and could therefore prescribe medicines for specific clinical conditions. They maintained their skills and knowledge and obtained 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. Assistant practitioners were trained to administer vaccines against a patient specific direction from a prescriber. We noted that the records of patient medicine reviews were not always completed despite clear evidence that patients had attended appointments for reviews of their health care needs. The practice responded quickly to this observation and confirmed they would take action to ensure this was actioned.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration and appropriate insurance for clinical staff was up to date and valid.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice landlord had supplied the practice of the building fire risk

assessment and weekly fire alarm checks were undertaken. 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 copies of other risk assessments in place for the premises such as asbestos 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. A weekly spreadsheet was maintained which identified the availability and scheduling of each GP for morning and afternoon surgery. The schedule also detailed the number of GP patient appointments available each day. GPs and nurses spoken with confirmed they supported each other by monitoring each other's patient lists and they could see a colleague was running behind and they had capacity they took over seeing some of the waiting patients.

Arrangements to deal with emergencies and major incidents

The practice had 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.



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 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. We saw clinical audits referred to current guidance as a base line for best practice.
- All new guidance, including the Medicines and Healthcare Products Regulatory Agency (MHRA) updates came through to the practice medicine coordinator who ensured clinicians received this by email. Each GP had clinical lead responsibility for different clinical areas and they were responsible for reviewing existing practice protocols and procedures once an update was received for their clinical lead area.
- Clinical meetings were held monthly, where new guidance and alerts were discussed. Minutes of these meeting provided good evidence that changes to guidance were reviewed

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 practice supplied unverified data that they had achieved 97.2% of the total number of QOF points available for 2015/16. The most recent published results for the year 2014/15 showed the practice achieved 98.7% of the total number of points available, with a zero count for clinical exception reporting. The practice manager advised that the data available, which showed zero clinical exception reporting across all domains, was inaccurate and confirmed their rate of clinical exception reporting reflected the clinical commissioning groups (CCG) average of about 5.8%. (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. The practice achieved higher percentages in the QOF diabetic indicators for 2014/15 when compared to the CCG and the England averages. For example:

- The percentage of patients with diabetes on the register in whom the last blood test (HbA1c) was 64 mmol/mol or less in the preceding 12 months was 84% compared to the CCG average of 80% and England average of 78%.
- The record of diabetic patients with a blood pressure reading recorded within the preceding 12 months was 85%. The CCG average was 80% and the England average was 78%.
- The record of diabetic patients whose last measured total cholesterol 5mmol/l or less within the preceding 12 months was 87%, which was higher than both the CCG average of 84% and the England average of 81%.

Other data from 2014/15 showed the practice performance was comparable to the local and England averages. For example:

- 84% of patients with hypertension had their blood pressure measured in the preceding 12 months compared to the CCG average of 85% and the England average of 84%.
- 75% of patients with asthma, on the register had an asthma review in the preceding 12 months compared to the CCG average of 76% and the England average of 75%.
- 91% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was slightly higher than the CCG average of 87% and the England average of 84%.
- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was higher than the CCG average of 91% and England average of 88%.

There was evidence of quality improvement including clinical audit.

The practice had an annual clinical audit plan, which was underpinned by the practice's annual development plan. The clinical audit plan identified the audits /re-audits that needed reviewing for the coming year month by month and showed when these had been completed. These were linked to national guidelines such as NICE. The GP clinical



Are services effective?

(for example, treatment is effective)

leads undertook clinical audits for their area of speciality. For example, the GP clinical lead for diabetes carried out first cycle audits in April 2016 for high risk of diabetes and 'Diabetes 8 aspects of care'. A third cycle audit was also undertaken 'Diabetes –NICE targets'. Practice nurses also carried out clinical audits – one nurse confirmed that they were about to undertake an audit of patients who had their spleen removed and their immunisation status. The practice was a GP training practice and trainee GPs were also actively supported and involved in clinical auditing.

- We reviewed evidence from two clinical audits that demonstrated improvements were implemented and monitored. The practice recognised that its prescribing of hypnotic medication was an outlier compared to other GP practices. Following the successful bid for transformation funding at the end of 2014 the practice commissioned the local Addiction and Dependency Service (ADS) to provide a weekly session at the practice for a three month period. Patients who struggled with their reduction programme were referred to ADS rather than seeing a GP. ADS continued providing support at the practice after the expiry of the commissioned three month period until September 2015. Data collections were undertaken in December 2014, September 2015, December 2015 and June 2016. These showed a continuous reduction in the number of patients receiving hypnotic medication and resulted in reducing expenditure on these medicines. For example in December 2014 400 patients were receiving hypnotic medicine at a cost of £5,803.32, at the final data collection in June 2016 228 patients were receiving this medicine and the expenditure was £519.90. The practice had achieved a 43% reduction in prescribing this type of medicine to patients whilst reducing expenditure by 91%.
- The second clinical audit was of the diagnosis of hypertension. This referred to NICE guidance. Searches were undertaken to identify patients newly diagnosed and those patients with a raised clinic BP but no diagnosis of hypertension between April and September 2015. This initial search identified problems with read coding (the recording of information consistently within the patients' electronic record) and that 97% of patients were being treated correctly. Actions were identified, including adapting the hypertension diagnosis template to make comprehensive recording of blood pressure data and identification of treatment easier. A further

audit was undertaken in July 2016. This identified 100% of patients were treated correctly and 97% of patients were coded on the hypertension diagnosis template correctly. A further audit was scheduled for December 2016.

- A range of other audits were available including menopause diagnosis, minor surgery and coil insertions.
- The practice monitored and bench marked its performance. For example, the practice participated in the CCG strategy of allocating care homes to specific practices, which resulted in a 10% drop in admissions to hospital from care homes across Stockport. However, data showed that this drop in admissions was not reflected for the GP surgery and admissions had increased by 16%. An audit and analysis of the reason for this was undertaken and the outcome of this discussed with the care home manager forum meeting to identify strategies to reduce admissions to emergency departments. This included a review of advance care plans. The actions implemented as a result of the audit were effective in reducing the number of admissions by 22%.
- The practice was implementing a programme of patient pulse checks for those over 65 years of age to identify those with an irregular pulse (atrial fibrillation).
- The practice also participated in pilot schemes including providing practice based assessment and treatment of skin lesions and using the 'GP Consultant Connect' scheme to discuss specific patient health care conditions directly with a hospital consultant.

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. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Annual refresher and or update training was also provided as required and this included basic life support. Staff had access to and made use of e-learning training modules and in-house training.
- 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 vaccinations and taking



Are services effective?

(for example, treatment is effective)

samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations 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. In addition, one practice nurse was a non medical prescriber and was trained in insulin initiation. They were supported by the practice's GP clinical lead for diabetes who had advanced training in the management of this and was a GP with a Special Interest (GPwSI).

- One GP was an Associate Dean for Health Education North West and they were one of the three GP trainers and had supported three medics who were in their third year of GP Speciality training (ST3) in 2016. In addition, the practice were part of a pilot scheme supporting foundation year one doctors. (Foundation training is the two year additional training programme doctors require after completing medical school and qualifying as a doctor). The training provided to trainee GPs had and continued to provide the practice with a recruitment pool of GPs who wanted to work there.
- One practice nurse was also a student nurse supervisor.
- GPs had designated lead for each clinical areas. In addition, three GP partners had extended training (GPwSI) and expertise in the management of diabetes, cardiology and drug and alcohol misuse.
- 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 ongoing support during sessions, one-to-one meetings, appraisals, personal development plans, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses.

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 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.
- The practice was proactive in supporting patients on the palliative care register and used an electronic communication tool to record information that was accessible to the Out of Hours provider and the local hospital. This ensured that clinicians could provide the right level of care and treatment in accordance with patient wishes.

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 ongoing 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 regular basis including palliative care meetings, multi-disciplinary complex care meetings and safeguarding meetings.

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.
- The practice provided care and treatment to approximately 230 patients living in five local care homes. GPs and practice nurses were aware and knowledgeable of patients living in care homes who had Deprivation of Liberty Safeguards (DoLS) plans in place or applications pending. The practice had met with their local MP to raise concerns about DoLS and the distress they caused to bereaved families who had to wait for a coroner 's inquest (if the patient was subject to a DoLS) before they could bury their deceased relative. The MP had raised the issue in parliament.
- 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.
- The process for seeking consent was monitored through patient records audits.



Are services effective?

(for example, treatment is effective)

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, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice had been actively monitoring patients in the last 12 months for the prevalence of pre-diabetes. This had resulted in an increase of over 250 additional patients being identified as at risk of developing diabetes. Patients were advised of this risk and offered support. An awareness and education course DESMOND (Diabetes Education and Self Management for Ongoing and Diagnosed) was available close to the surgery from the beginning of December 2016.
- The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG and England average of 82%. The practice sent reminder text messages, letters and calls to patients who did not attend for their cervical screening test. There were systems in place to ensure results were received for all samples sent for cervical screening and the practice followed up women who were referred as a result of abnormal results.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening, although data supplied from the National Cancer Intelligence Network (NCIN) indicated that the practice's screening rates for breast cancer and bowel cancer were lower than the CCG and England averages. The practice was aware of this and had identified a practice cancer champion who was working with Healthy Stockport to encourage patients to either attend appointments for screening or complete and return postal screening tests. The practice cancer champion provided examples whereby they contacted patients to advise and encourage them to attend the breast screening service that was located at the GP practice for six weeks. In addition, the Healthy Stockport representative who worked with the practice offered patients additional support on any breast related issues. The cancer champion also contacted patients to ask and encourage them to complete and return the bowel screening kits sent to them. The cancer champion stated that patient feedback regarding this test was they were unwilling to do the test.
- Childhood immunisation rates for the vaccinations given were similar to the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 75% to 95% compared to the CCG range of 69% to 91%. Data for five year olds ranged from 88% to 93% compared to the CCG range of 85% to 92%. However the practice told us that their data showed that they consistently achieved over 95% of childhood immunisation rates for both age ranges.
- Data supplied by the practice for its flu campaign for 2015 showed they performed better than the CCG average across all population sectors (over 65s, at risk, pregnant women and children 2-4 year old).
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 35–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

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.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; 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.

We received 30 Care Quality Commission comment cards, 27 of which were 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. Comment cards detailed specific experiences of personalised support they received from GPs at times of bereavement and in situations of vulnerability such as homelessness. We spoke with four patients (one on the inspection day and three by telephone the following day) who all confirmed they were very happy with the quality of service they received. In addition one newer patient compared this practice with other GP practices they had been registered with previously and stated that they could always get an appointment and all GPs and reception staff were helpful and supportive. Patients told us they could get appointments when they wanted and were willing to wait the couple of days if needed to see a GP of their choice. One patient told us that they regularly saw the same GP who was sympathetic, supportive and instrumental in their recovery.

The practice analysed the results of the GP patient survey, comparing the results from previous surveys and monitoring the feedback from patients and timetabling additional reviews and evaluations.

The results from the most recently published GP Patient Survey (July 2016) rated aspects of the care and service provided to patients similar to the Clinical Commissioning

Group (CCG) and England averages. Results from the national GP patient survey showed patients felt overall that they were treated with compassion, dignity and respect. For example:

- 83% of patients said the GP was good at listening to them compared to the CCG average of 92% and the England average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 91% and the England average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the England average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the England average of 85%.
- 88% 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 the England average of 91%.
- 98% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 98% and the England average of 97%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the England average of 87%.

Care planning and involvement in decisions about care and treatment

The practice confirmed that 2% of the patient adult population had a care plan in place. We saw that care plans were recorded for unplanned admissions to hospitals and patients with dementia. In addition, patients with asthma and chronic obstructive pulmonary disease (COPD) had personalised management plans and were provided with medicine rescue packs containing antibiotics and steroids.

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 positive and aligned with these views. We also saw that care plans were personalised.

Are services caring?

However, results from the national GP patient survey showed patients' responses were slightly below the average responses for the CCG and England. For example:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the England average of 86%.
- 77% 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 England average of 82%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average 88% and the England average of 85%.

The practice manager analysed and reported on the GP patient survey results, identifying areas of improvement and deterioration in scores from patient feedback. A scheduled review of the recent results was planned for late October 2016.

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.

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. In addition the practice provided additional services to support their patients. For example:

- The practice was working with Healthy Stockport to provide a weekly open door drop in service at the practice where patients and people living in the community received advice and signposting to support with lifestyle choices. We spoke with a member of the Healthy Stockport team who stated that the weekly visit was a community focal point for the local community. They provided an example where a socially isolated patient was supported to become an active volunteer in the local community and told us about the support they provided to Public Health England and the practice in encouraging patients to attend for breast screening.
- Case reviews of patients showed that GPs worked hard and consistently with patients to help and support them with physical and mental health issues and social issues such as homelessness and bereavement.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 362 patients who were carers, (approximately 4% of the practice list), 226 of these were under 65 years of age. In addition to the weekly visit by Healthy Stockport, written information was available to direct carers to the various avenues of support available.

Staff told us that if families had suffered bereavement, their provided support in accordance with the patient's wishes. One patient told us of the personal and regular support they received from one of the GPs, which had been invaluable to them, assisting them to cope better.



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.

- The practice offered evening appointments with a GP, a practice nurse and a health care assistant on Monday evenings until 7.30pm and early morning appointments were available from 7am on Fridays.
- The practice provided care and treatment to five care homes with total of 230 patients. Each care home had a designated GP who visited the care home weekly. This reduced the number of requests by the care homes for urgent visits and ensured continuity of care for patients. Additional visits were provided in an emergency.
- The GP partners attended care home manager meetings every second month, where all care home managers were invited to discuss issues affecting them, to review any safeguarding issues and review patients receiving end of life care.
- One GP had designated responsibility for providing care and support to patients with a learning disability living locally in supported tenancies. This provided continuity of care and established positive working relationships with the patients and their care team and the wider learning disability medical team based at the local hospital.
- Another GP was the lead for providing care and treatment to 22 patients requiring intermediate care accommodated in two care homes.
- Each practice nurse was also the named nurse for each care home. They visited the care homes regularly to review patient care plans. One practice nurse told us how she supported staff at a care home by providing informal training and information on diabetes, urinalysis and when to contact a GP.
- The practice nurses visited housebound patients, those with a long term condition and patients at risk of unplanned admission to hospital and carried out an assessment and recorded a care plan with the patient and / or their carer.
- The practice provided a full range contraceptive services including long-acting reversible contraception, such as coils and implants.
- The practice had trained an assistant practitioner to support patients with 24 hour blood pressure monitoring (Ambulatory Blood Pressure Monitoring (ABPM)). The audit cycle for of the diagnosis of hypertension in 2015 and 2016 identified that the use of APBM had been instrumental in identifying patients with a raised clinic blood pressure reading who had not been diagnosed as hypertensive or had a normal 24 hour monitoring test.
- There were longer appointments available for patients with a learning disability or special health care needs
- The practice offered twice yearly reviews of patients with dementia and care plans were recorded for these patients.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice sent out 'case finding' questionnaires to patients over 65 years to identify any unmet health care needs.
- The practice facilitated and supported the provision of additional medical services from the practice to enable patients to access these. For example, a consultant psychiatrist worked from the practice one day per month, a weekly shared care drug misuse clinic was held and a consultant led ADHD clinic operated every second month at the practice.
- A mental health care navigator was employed by the practice to provide support and guidance to patients promoting improved mental health wellbeing. In 2012 the practice worked with a number of other agencies including voluntary charities (FLAG, (For Local Advice and Guidance) Stockport MIND & All Together Positive) to support and improve mental health wellbeing of the practice patient population. The target population was for people with low mental wellbeing and or depression, anxiety and psychological stress. The pilot was reviewed 18 months after implementation to analyse its effectiveness. This identified that patients who used the service led to a reduction in attendance with a GP and there was also a reduction of patients being referred to the single point of entry (SPOE) mental health services. The funding was withdrawn for the service but the practice used GP development funding to recruit a Mental Health Care Navigator to continue to offer this service to patients with lower level mental health issues by supporting them and signposting them to other services.



Are services responsive to people's needs?

(for example, to feedback?)

- The practice facilitated in house supportive initiatives for the practice's patient population. This included weekly visits by Healthy Stockport, which provided an open door drop in service at the practice where patients could get advice and signposting to support for social issues, lifestyle choices including diet, alcohol and drugs use.
- The practice promoted patient access to a range of community health care support initiatives including patient education programmes for the self-management of long term conditions such as diabetes.
- Patients were able to receive travel vaccinations available on the NHS.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday, with extended hours for GP, practice nurse and assistant practitioner appointments on a Monday evening until 7.30pm and Friday mornings from 7am. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available each day for people that needed them. Patients could book appointments on line and we heard that 17% of the practice population had an active on line account.

Results from the national GP patient survey (July 2016) showed that patient's satisfaction with how they could access care and treatment was better than local and national averages.

- 87% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 76%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 73%.

The practice manager was proactive in responding to patient demand for access and appointments and in second half of 2015 had altered reception staff workload to enable the availability of three reception staff at all times to respond to patients either directly or on the telephone. A fourth staff member was also available to provide additional support if required. The practice monitored patient appointment availability and introduced telephone

consultation in July 2015. In addition, GP appointments times had also been increased to 12 minutes. The practice's development plan for 2016-17 identified that further audit of patient waiting times was scheduled for November 2016.

Patients we spoke with stated they could always get an appointment and were satisfied with the practice appointment system. Feedback comment cards also reflected this view. Patients did say that the surgeries did run late but accepted this as a consequence of the GP spending the time that was needed with each patient.

Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. The practice had an easy read policy in place for staff to respond to specific health care needs including when to call for an emergency ambulance and when to speak with a GP.

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

The practice had received 15 complaints in the last 12 months (November 2015 to October 2016). We reviewed three of these. We saw that complaints were responded to appropriately in a timely way, with openness and transparency. The complaint investigation and response to the complainant contained detailed information and chronology of events, the outcome of an investigation, an apology where appropriate and information about any changes implemented as a result of the complaint. The practice provided clear evidence of following their policy on the Duty of Candour.

Some complaints were also investigated as significant events, which were reviewed at the monthly clinical meetings. Minutes of the clinical team meetings and the evaluation of changes implemented as a result of investigations demonstrated that the practice used the learning from complaints to improve the quality of service they provided to patients.

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 clear vision to deliver high quality care and promote good outcomes for its patients. The practice's mission statement was "The members of this practice aim to work together in a friendly, supportive, innovative and non-discriminatory way to provide the highest quality of patient care". The practice partners confirmed that the mission statement was reviewed at least annually with the whole team at one of the 'away' days.
- There was a commitment by all the practice staff to deliver a quality service. The practice's ethos to support the health and social care needs of their patient population in an area with high levels of deprivation was underpinned by a comprehensive practice development strategy and plan, reflecting the vision to provide the highest quality of care.

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 and how they contributed to the practice's vision of delivering patient centred care.
- Practice specific policies were implemented and were available to all staff. The practice's governance arrangements were supported by monthly clinical and administration meetings. These provided staff the opportunity to keep up to date with changes as result of significant event analysis, clinical audit and to share learning from patient case reviews.
- There were clear clinical and non clinical leadership roles for all staff that reflected the team member's areas of expertise and qualification. The practice encouraged inclusive team work and all staff had been allocated specific areas of responsibility and leadership. GPs and nurses led on clinical areas and administrative and reception staff members were allocated responsibilities commensurate with their role and experience.

- A comprehensive understanding of the performance of the practice was maintained. There was a strong commitment to patient centred care and effective evidence based treatment. The practice benchmarked their performance and took action to improve where there were shortfalls. For example, the rate of unplanned emergency admissions from the five care homes allocated to the practice; auditing and implementing strategies to improve this including working with the care home managers resulted in a decrease of emergency admissions.
- A comprehensive programme of continuous clinical and internal audit was in place which was used to monitor quality and to make improvements. The practice supported trainee GPs to carry out clinical audits and facilitated them with opportunities to present their findings and any patient case reviews they undertook at the practice clinical meeting.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. These were reviewed regularly.
- The practice staff team were active in the clinical commissioning group (CCG) and the wider primary medical service provision for Stockport. For example, GP partners were CCG leads for Safeguarding and IT. One partner was the CCG locality chair and two partners (one GP and the practice manager) were members of GP Federation (Viaduct) leadership council for the Tame Valley neighbourhood.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

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 knowing about notifiable safety incidents. The practice told us about an example where they had implemented their duty of candour policy.

When there were unexpected or unintended safety incidents:

Are services well-led?

Good 

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They 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 was the place where everyone wanted to work. Jobs only became available when someone retired.
- 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 in doing so and felt supported if they did.
- One of the practice's salaried GPs was the practice's 'Speaking Up Guardian' and provided a point of contact for staff who may wish to implement the whistleblowing policy.
- Team away days were held twice per year and these included a review of the practice's vision, the practice development plan, training such as safeguarding, and a 'fun' team building exercise.
- Staff said they felt respected, valued and supported, particularly by all 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.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice did not have a patient participation group (PPG). The practice told us they had struggled to gain any interest or support for a PPG. However, for patients with internet access, the practice did have a Friends of Brinnington Surgery Facebook page, which the practice stated was a virtual patient reference group. This was accessible once the patient had been accepted as a friend by the Brinnington Surgery Facebook account. The Facebook page was used to share information and seek and receive patient feedback. Two patients we spoke with were members of the Friends of Brinnington Surgery Facebook page and they found it useful to

provide and receive feedback about the surgery. The practice manager confirmed that there was over 300 patients registered as 'friends', 30 of which communicated regularly through this media.

- The practice analysed the results of the GP patient survey, comparing the results from previous surveys and monitoring the feedback from patients and timetabling additional reviews and evaluations
- The practice had gathered feedback from staff through staff away days 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 strong 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. For example:

- The practice recognised the impact of the high level of social and financial deprivation in the local community area was responsive and effective at trying to bring supportive services into the practice to enable patients to access these.
- The practice promoted close working relationships with a range of health and social care professionals to ensure that patients' needs including physical and mental health and social care needs remained a priority.
- The practice provided strong leadership in ensuring safeguarding procedures for children and vulnerable adults was high on the agenda both for the practice and CCG.
- The practice recognised gaps in service provision and quality and used the significant event procedure effectively to share learning and drive improvements.
- The practice was a long standing teaching and training practice, three partners were trainers and as a result of training the practice had been able to recruit GP partners from the scheme. The practice was currently providing training and support as part of a pilot scheme to year one foundation-training doctors.
- The practice provided allocated GP cover to each of the five care homes, the two learning disability supported tenancies and intermediate care services for 22 patients.