Boundary House Medical Centre

Inspection report

Boundary House,
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Cheshire
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous rating April 2015 – Outstanding)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at Boundary House Medical Practice on 1 October 2018 as part of our inspection programme.

At this inspection we found:

- The practice had strong systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice habitually reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they could access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding responsive practice :

- The practice was very responsive and arranged its services to meet the requirements of the patients as much a possible. For example, they introduced Walking for Health – with 15-20 people walking weekly. They now have five patients trained as walk leaders. The scheme was so successful it is now part of a development across Trafford helping other GP surgeries to facilitate their own walking groups.
- In response to meeting with a patient, the practice undertook an audit to identify patients on the autistic spectrum. A significant number were not receiving structured health checks because of their lack of engagement. As a direct result, specific structured invites were sent and the practice now provided structured invited health checks for all patients on the autistic spectrum.
- Specific training was provided to a member of staff when patients suggested that extra help was required for those with mental health conditions. Coffee/tea mornings and exercise groups were introduced to combat loneliness in the community. Fundraising was undertaken to raise money for a community defibrillator after the one at the practice was borrowed on several occasions. Collections for the local food bank were organised and five deliveries had been provided.
- A free acupuncture service was offered resulting in lower prescribing for pain relief medicines and lower referrals to secondary care services
- Overall, we saw that the practice responded wholeheartedly to suggestions and advice it received from its patients.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and a second CQC inspector.

Background to Boundary House Medical Centre

Boundary House Medical Centre, is located in Sale in an old house where they have been based since the practice opened. They offer services under a General Medical Services contract to approximately 10,500 registered patients, with the highest population group being adults and young children. The population is mostly white British living in an area marked at number five on the scale of deprivation (where 10 is the least and one is the most deprived). The surgery is easily accessible with good public transport links and is equipped to accommodate patients with disabilities.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures, and treatment of disease, disorder and injury.

Regulated activities are delivered to the patient population from the following address:

462 Northenden Road

Sale

Cheshire

M33 2RH

Practice staff consisted of three male partners and three female salaried GPs. There was also three GP third year specialist trainees and a GP retainer (a GP returning after training completed), two practice nurses, three health care assistants and an associate clinical practitioner in training. This was a newly appointed two year training programme. In addition, the practice hosted a clinical pharmacist also under a two year training programme. The clinical staff were supported by a practice manager, an office manager and a team of reception and administration staff.

The practice is open from 8am until 6.30pm Monday to Friday and closed at weekends. On Tuesday morning from 7am and Friday morning from 7.30am extended hours are offered. The telephone lines are open from 8am until 6.30pm daily and outside of those hours (including Mondays between 1pm and 2pm) the phones are diverted to the Out of Hours Provider, Mastercall.

Since our last inspection in January 2015 the practice has maintained the excellent standard of service provided to its population. However, since 2015 outstanding features have become more embedded across general practice.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had strong systems in place to keep people safe and safeguarded from abuse.

- There were clearly implemented systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (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.)
- Staff took steps, including working with other agencies including IRIS (a service specifically related to domestic violence) to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were clear systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. All staff could cross cover in the absence of their colleagues.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Reception staff could provide examples where their training had utilised.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis and training had been provided to non-clinical staff.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff received and put in to practice information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was evident.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols and we saw evidence of this.

Appropriate and safe use of medicines

There were reliable systems for the appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.
- Processes and the use of templates within the clinical system were key to safety for all manner of events, particularly recall and read coding.

Lessons learned and improvements made

Good

Are services safe?

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were clear systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.
- The practice shared information and learning outside their organisation to the benefit of the wider community. We saw evidence and examples where other practices had introduced good practice that had originated at Boundary House.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- All staff had good knowledge of the clinical system which was used to its optimum for care planning and treatment to improve and support patients' independence.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. The practice nurse had recently undertaken the Warwick Course (postgraduate diabetic education) and provided guidance to the GPs and health care assistant on the subject.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- The practice's performance on quality indicators for long-term conditions was in-line or above all local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% for all indicators (average 96% and above).
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Young people could access services for sexual health and contraception.

Working age people (including those recently retired and students):

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had systems to inform eligible patients to have the meningitis vaccine for example before attending university for the first time.
- There were systems in place to call and recall patients for cancer screening programmes such as cervical and breast cancer. A volunteer offered by Trafford Clinical Commissioning Group had been utilised to increase the uptake of patients doing a bowel cancer screen.

People whose circumstances make them vulnerable:

Good

Are services effective?

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. Where appropriate discussions had taken place around end of life wishes and patient records were coded. In addition, clinicians were alerted to ensure those wishes were reviewed on a regular basis.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- An unexpected meeting with a patient outside of work prompted the practice to research, encourage awareness and identify autism within its population. The practice now has a register of patients on the autistic spectrum. Those patients are offered specific care plans, health checks, reviews and personalised services such as email communications, quiet rooms and longer appointments. Those services may not have been available previously because their disorder had not been identified.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- A member of non-clinical staff was taking a lead role in assisting patients with mental health disorders and was being trained as a first aider in mental illness.
- The practice had an affiliation with a new half-way house in the immediate area where all the residents had severe and enduring mental illness. There was an open communication with the manager of that service and the surgery.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.
- Clinicians also took part in monitoring the quality of the non-clinical elements such as staffing and the appointment system. We saw evidence of two non-clinical audits that had resulted in changes within the practice. One of them resulted in leaders providing a more open and inclusive attitude to all staff, and the other resulted in a change to the appointment system and reducing unsafe pressure on the duty GP.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.

Good

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice had protected time for an hour every Monday so that all staff could attend a practice meeting.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- A well attended walking group was in place with five patients now trained as walk leaders.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- When necessary, such as for surgical procedures, the practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were mostly above local and national averages for questions relating to kindness respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers could access and understand the information that they were given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers to find further information and access community and advocacy services.
- The practice used the care plans in its clinical system to their optimum level helping to facilitate involvement with patients about care and treatment.
- The practice proactively identified carers and supported them.
- The GP patient survey results were mostly above local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- The clinical system highlighted patients with sensitive issues so that staff knew before they arrived if additional assistance was required.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and the following population groups as outstanding : Families, children and young people, People whose circumstances make them vulnerable and People experiencing poor mental health (including people with dementia):

The population groups, Older people, People with long term conditions and Working age people (including those recently retired and students) and were rated as good.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patients' needs and preferences.

- The practice understood the needs of its population and tailored services specifically in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- The practice was proactive in making adjustments when patients found it hard to access services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice for any reasons.
- When older patients reported that they struggled to hear the GP calling them in to an appointment, the practice installed a viewing/call screen.
- The health care assistant habitually contacted older patients reminding them of appointments, improving attendance, reducing isolation and improving regular follow up.
- The practice used the clinical system to its optimum alerting all staff to next of kin, information sharing, disability and mobility issues and any advanced wishes or plans.
- Blister packs, organised receipt of medicines and medicine reviews were regularly monitored

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice nurse prescribed medicines and managed hypertension, asthma and chronic obstructive pulmonary disorder to a high degree of competency.
- Trafford Health "Enabling exercise" held monthly clinics at the practice.
- A cancer champion (a member of the administration team) regularly updated the practice and promoted cancer UK events.
- The practice held regular quarterly cancer care review meetings including rates of diagnosis, diagnostic pathways and auditing of expected/unexpected deaths. These meetings were attended by the district nursing team, MacMillan and hospice staff.
- New patient medicals were maximised allowing for early coding and follow up to prevent discontinuity of care.

Families, children and young people:

- The need for a community defibrillator was identified. The practice had set up a fundraising project for this and was using their in-surgery walking group to raise sponsorship.
- Child immunisations rates were above the local and national averages. There was a proactive system in place to follow up any non attenders for child vaccinations. The practice nurse and/or the practice manager telephoned the patients and the nurse would then arrange a home visit for immunisation if the parent agreed. This had increased the uptake of vaccination against childhood diseases.
- There were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Telephone and GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

Are services responsive to people's needs?

- All staff had received IRIS (domestic violence) training.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offered text as a way of providing positive test results (with consent from patients) rather than them having to ring the practice. This had received positive feedback from patients and was being well used. It had saved patient and clinical time.
- A free acupuncture service was offered resulting in lower prescribing for pain relief medicines and lower referrals to secondary care services.
- As a result of heavy investment in training for the medicines management team, prescriptions were usually processed within twenty-four hours of request.
- There was a full family planning service including coil and implant fitting/removal and emergency contraception.
- The practice has actively invited 18-24 year olds for the MENACWY vaccination and encouraged uptake of the R-U-Clear programme.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Early opening was offered two days per week. Regular audits were undertaken and there was evidence that this service was well used with positive feedback from patients.
- Appointment times were reviewed regularly, and altered if necessary, to ensure the practice was meeting the demands of the population. Each day the practice provided on-the-day appointments triaged by the GP and offered based on clinical need. To enable the practice to manage this safely there was a protocol in place that when the duty GP felt they had reached a safe capacity they would report to the manager and admin team for review.
- Flu clinics were offered on Saturdays to avoid working days.
- Text services included the additional facility to send web links and patient information leaflets.

People whose circumstances make them vulnerable:

- The practice understood that exercise was important to combat many conditions including loneliness and social isolation. They set up a walking group which became so successful it was initiated throughout the whole of Trafford where most GP practices have now adopted a similar model.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- The practice offered a collection service to a local food bank. To date five collections had been donated. This had raised awareness in the community about people who were most vulnerable.
- The practice held a register of patients living in vulnerable circumstances such as homeless people, people on the autistic spectrum and those with a learning disability.
- There was dedicated clinics for patients with learning disabilities that focused on the whole patient. Easy read invitations were sent to encourage physical and directed health checks.
- Patients on the autistic spectrum were identified and invited for specific double-appointment health checks. This had been introduced as a direct result of a chance meeting between the practice manager and an autistic patient. From that meeting the practice undertook an audit that had identified autistic patients who were not routinely attending the practice and were missing out on checks around smoking, obesity, high cholesterol and/or diabetes.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- All clinical rooms had clear notices of safeguarding contacts and access to links/forms via the intranet. Vulnerable patients were regularly discussed at practice meetings.
- The practice held petty cash for those patients genuinely unable to afford transport to onward services if necessary following consultation.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Outstanding ☆

Are services responsive to people's needs?

- Patients with mental health conditions identified a need for extra assistance when feeling distressed or agitated whilst attending the surgery. As a result of that identified need a member of staff was sent on a course and was now upholding the role of mental health first aider.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP and encouraged to attend.
- Open communication and support was provided to a newly set up residential home nearby, for people with severe and enduring mental illness.
- There was a weekly in house community drug team service and a monthly health-trainer clinic encouraging activity with options of referral to local leisure services.
- The practice was very aware of social isolation and had introduced regular coffee/chat with your GP mornings to encourage group discussions and patient attendance at the surgery.

Timely access to care and treatment

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and that it was regularly reviewed and changed if necessary to accommodate demand.
- The practice's GP patient survey results were mostly above local and national averages for questions relating to access to care and treatment. For example 100% of respondents had confidence and trust in their GP and 100% of respondents said their needs were met at their last appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice treated every complaint as formal and acted on it accordingly whether received verbally or in writing.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There had been a stable leadership of three partners for four years and a consistent team of salaried GPs, one who had stayed on after completing their training.

Vision and strategy

The practice had clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.
- There was a shared vision for the future. The practice held regular meetings keeping everyone up to date and making sure the whole practice was involved. Discussions around how to deal with upcoming changes within the area were already being facilitated rather than waiting and acting reactively.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued and were proud to work in the practice. A staff survey was undertaken in July 2017 so that both clinical and administration staff could make suggestions for improvement. There was an action plan in place to implement those improvements that all staff had agreed.
- The practice focused on the needs of its patients and searched for areas where improvements could be made.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. Staff received training and guidance about practice expectations.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that those would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff and we saw evidence of support being provided when required. There was an open door policy for discussions about staff wellbeing.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

Good

Are services well-led?

- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice and its staff acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. The clinical system was used to its optimum improving care planning.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services and to improve relationships within their community.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The practice had a working patient participation group of eight pro-active members formed from 32 patients. They took ownership and advised the practice of what they could being doing better. The practice made changes as a result of feedback from the group.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. The current GP trainers mentored ST1-ST3 GP trainees. They also mentored trainees in difficulty across the North-West.
- Three of the current GPs were previously trainees at the practice.
- The practice hosts medical students from Manchester university for PEPs (on hold) and two have become trainees.
- Trainee student nurses and HCA trainees have been supported at the practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- Initiatives originating at this practice had been introduced throughout Trafford and was being used by other practices, such as the walking group.
- The practice actively seeks out developments and adopts a positive active outlook to challenges. They

seek to consistently improve and have introduced a text messaging service that they have used not just for appointments but to text results and send out patient literature.

- The practice is a “research active organisation”, recognised by the local clinical research network. They have invested heavily in time and resources to support research. All staff have been trained to "Good clinical practice” standards.
- The practice has invested and hosts local research nurses and delivers active research projects on a regular basis. As an example, within the last 12 months the practice has delivered Orion 11 study - a randomised controlled double blind trial of the use of Inclisiran (a medicine for lowering cholesterol). Patients were recruited successfully (highest rate of recruitment across Greater Manchester) and as a result offered them extra investigations and monitoring as part of the study.

Please refer to the evidence tables for further information.