Boundary House Medical Centre

Quality Report

462 Northenden Road
Sale
Cheshire,
M33 2RH
Tel: 0161 972 9999
Website: www.boundarysurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Boundary House Medical Centre on the 22nd January 2015 as part of our comprehensive inspection programme.

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

The provider was rated as outstanding for effective, responsive and well led which led to this rating applying to older people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia) population groups. We rated safe and caring as good.

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 used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example working in partnership with the community matrons, drug and alcohol workers and participating in research such as the Salford Lung Study to improve outcomes for patients.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- A children's immunisation and vaccination programme was in place. The practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- We found the practice proactively engaged in research and clinical studies to inform good practice and looking at new ways to improve outcomes for patients. We saw the practice was involved in the Salford Lung Study and an Asthma study. Initial results showed positive impact on patients who experienced fewer or no episodes of acute exacerbation.
- One GP provided a free acupuncture clinic for patients with various conditions such as muscular-skeletal conditions, migraine, fibromyalgia and chronic fatigue syndrome. Audits showed a 70% response rates with reduced referral rates to secondary care and a reduction in prescribing costs.
- We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 91% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate, above the local CCG average. We saw care plans were also in place for patients at risk of unplanned hospital admissions and those aged 75 and over who were vulnerable.
- We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14, a survey of 198 patients undertaken by the practice's patient participation group (PPG) and the friends and family test. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 95% of respondents described their overall experience of this surgery as good and 94% said the last nurse they saw or spoke to was good at treating them with care and concern.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to other practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient

Summary of findings

participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding 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. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the population group of older people. Nationally reported data showed the practice had better than average outcomes for conditions commonly found amongst older people. The practice had a register of all patients over the age of 75 and these patients had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework. This means they work, as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

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

We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place. A designated GP was assigned to initiate/review

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice worked closely with the community matrons for patients who had acute conditions to prevent hospital admissions. Patients who were on the unplanned admissions register were contacted following admissions to identify any changes to care and treatment required and reviews of care were discussed at practice meetings.

Clear alerts were placed on the appointment system highlighting vulnerable patients to ensure reception staff acted in a timely manner and allocated same day appointments or home visits. A recall system was in place for chronic disease areas with a dedicated

member of the administration team arranging recall appointments/ home visits and informing patients. Patients with multiple long-term conditions were provided with one-stop reviews for all areas following appropriate investigations.

The practice provided a diabetic clinic which offered patients an annual 50 minute appointment to review their condition. The appointments included time with a nurse and GP to ensure their care and treatment needs were being met. The practice nurse followed up all patients who had experienced chronic obstructive pulmonary disease COPD exacerbations

The practice monitored the needs of those patients with a cancer diagnosis and/or those on the palliative care register. They did this on a quarterly basis to ensure continuity of care and engaged with other health and social care providers where required.

Families, children and young people

Good

The practice is rated as Good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families who were at risk.

Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, we saw evidence to confirm this. We saw that staff dealing with young people under 16 years of age without a parent present were clear of their responsibilities to assess Gillick competency. Sexual health, contraception advice and treatment were available to young people including chlamydia screening. Referrals were made to the local young people's sexual health service.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Immunisation rates were high for all standard childhood immunisations.

All of the staff were very responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell. Written invitations were sent to new parents for eight week checks and a weekly baby clinic with health visitors was available for immunisations. Non-attenders were followed up by practice nurses/GPs and where appropriate home visits arranged.

Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. A GP took the lead for safeguarding with the local authority and other professionals to safeguard children and families. Where patients were suspected to be victims of domestic violence,

this was recorded within patient records and staff were vigilant and made appropriate referrals where necessary. Staff were also aware of the needs to protect children from exploitation and provided examples of joint working to protect vulnerable young people. Where required the practice facilitated safeguarding case meetings in the surgery involving police/social workers on the day for safety of at risk children.

The practice was proactive in providing palliative care for children, working as part of a multidisciplinary team to meet the needs of the child and family. This included daily visits, vigilance and end of life care at home.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

New patient medical assessments and NHS health checks were offered to patients. These were used to gather detailed information from patients enabling the practice to offer timely interventions, treatment and education to prevent deterioration in patients' health and manage any long term conditions identified.

Patients were provided with a range of healthy lifestyle support including smoking cessation with referrals available to external agencies to support people in leading healthier lifestyles. The practice worked together with community drug and alcohol workers who provided weekly sessions to patients at the practice.

The practice had extended opening hours enabling people to make appointments outside normal working hours. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

A full family planning service was available, including coil and implant fitting/removal and emergency contraception.

The practice achieved good uptake of flu vaccinations and offered flu clinics on a Saturday to allow flexible access for patients. The practice offered meningitis enhanced services to students, and encouraged uptake of chlamydia screening.

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

Summary of findings

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. The practice had a dedicated learning disabilities clinic that focused on the patient as a whole looking at the physical, emotional and social needs of patients.

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

For patients where English was their second language, the practice had close links with interpreter services and easy access to language line.

To encourage and enable vulnerable patients to attend appointments the practice covered the cost of transport for those genuinely unable to afford it themselves

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

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicine review. Nurses actively engaged with patients to encourage attendance for reviews by telephone in particular for frequent non-attenders. Practice nurses carried out monthly home visits for frail elderly patients to provide antipsychotic injections.

Staff had access to advice directly with a local community mental health nurse. The practice worked with a local psychiatric consultant, which included a weekly open advice line with the consultant directly.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. They actively screened patients who were displaying signs or at risk of dementia using a professionally recognised tool.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients. We reviewed five CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 95% described their overall experience of this surgery was good, higher than the national average and 89% would recommend this surgery to someone new to the area.

Outstanding practice

- We were told the practice proactively engage in research and clinical studies to inform good practice and looking at new ways to improve outcomes for patients. We saw the practice was involved in the Salford Lung Study and an Asthma study.
- One GP provided a free acupuncture clinic for patients with various conditions such as muscular-skeletal conditions, migraine, fibromyalgia and chronic fatigue syndrome. Audits showed a 70% response rates with reduced referral rates to secondary care and a reduction in prescribing costs.
- We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 91% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate, above the local CCG average. We saw care plans were also in place for patients at risk of unplanned hospital admissions and those aged 75 and over who were vulnerable.
- We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14, a survey of 198 patients undertaken by the practice's patient participation group (PPG) and the friends and family test. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 95% of respondents described their overall experience of this surgery as good and 94% said the last nurse they saw or spoke to was good at treating them with care and concern.

Boundary House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Boundary House Medical Centre

Boundary House Medical Centre provides primary medical services in Sale, Trafford from Monday to Friday. The practice is open between 8:00am and 6:30pm Monday, Wednesday and Thursday, 7:00am to 6:30pm Tuesday and 7:30am to 6:30pm on Friday.

The practice provides home visits for people who are not well enough to attend the centre.

The practice has three GP partners and three salaried GPs, two practice nurses and two health care assistants.

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

Boundary House Medical Centre is situated within the geographical area of NHS Trafford Clinical Commissioning Group (CCG). The practice also accept patients from Manchester as they are on the boundary between the two CCGs

Boundary House Medical Centre is responsible for providing care to 9200 patients of whom, 48.93 % are male and 51.07 % are female. Patients are just above average national levels of deprivation with 5.53% black and minority ethnic (BME) patients.

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

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 22nd January 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with nine patients and sixteen members of staff. We spoke with a range of staff, including receptionists, the practice manager, GPs, practice nurses, health care assistants and Specialist GP trainees.

We reviewed five Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place to monitor patient safety utilising a wide range of data and information available to them. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an achieving practice (The outcome standards represent the basic patients should expect to receive from general practice.) Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events.

Policies and procedures were in place and readily available to staff to report, investigate and act on incidents of patient safety, this included identifying potential risk.

All staff we spoke with were aware of the procedure for reporting concerns and incidents, and were actively involved in quarterly significant event meetings, to discuss incidents and take forward learning. We reviewed significant event reports. The investigations and actions taken were clearly recorded as well as changes made to practice when required. This information had been cascaded to staff during team meetings or sooner face to face communication where required. We saw the practice had managed these consistently over time which evidenced a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints, carried out full clinical audits and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. This was evident from speaking with staff and reviewing minutes of partner and full staff meetings.

The practice had a system in place for reporting, recording and monitoring significant events. We saw from the practice significant events log, minutes of meetings and speaking with staff, they had carried out detailed investigations and provided detailed records of outcomes and actions taken in light of the significant events. Quarterly full staff meetings were in place for significant events to discuss findings and plan action to be taken in light of significant events. All staff told us the practice was open and willing to learn when things went wrong.

The practice had systems in place to respond to safety alerts, received by the practice manager and then cascaded to appropriate clinicians for action. Alerts were discussed and action to be taken disseminated during governance meetings.

Reliable safety systems and processes including safeguarding

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

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All staff had received safeguarding training which was updated annually. GPs and nurses had completed safeguarding training at Level three in March 2014.

All the staff we spoke with were able to confidently discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. Quarterly safeguarding meetings were held at the practice with a Health Visitor and where required Social Workers to ensure good communication and all parties were up to date with relevant information linked to children and families welfare. If reception staff had any concerns about a patient's welfare while at the practice, they could communicate these to clinicians prior to the patient being seen by the GP or nurse. Where concerns already existed about a family, child or vulnerable adult, alerts were placed

on patient records to ensure information was shared between staff and to encourage continuity of care. All those on the register were discussed at quarterly safeguarding meetings.

We spoke with the lead GP for safeguarding; they had completed training to level three and were knowledgeable about the contribution the practice could make to safeguarding patients and were proactive in raising concerns to the Local Authority and police where required, with evidence recorded as part of safeguarding records. Clinical staff were aware of their roles to maintain patient's safety. These included areas such as domestic violence, child sexual exploitation and female genital mutilation. We were provided with details of cases where young women were subject to potential exploitation. We saw specific evidence where action had been taken to safeguard young women in potential danger. We saw the practice was proactive in reflecting on safeguarding issues and carrying out significant event analysis to look at learning from cases. These were discussed and minuted as part of quarterly safeguarding meetings and where appropriate learning would be shared with all staff as part of full staff significant event meetings.

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

Medicines Management

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

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

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

Medicine audits were routinely being carried out. The practice was responsive when new advice was received and carried out medicine audits appropriately. We saw evidence that changes to medicine prescribing were made when required such as changes to diclofenac (anti-inflammatory drug used to treat pain and inflammation associated with arthritis) following a completed audit cycle.

GPs reviewed their prescribing practices as and when medication alerts were received. Staff told us information and changes to prescribing were communicated during meetings, or via email alerts. Staff told us they regularly discussed and shared latest guidance on changes to medicines and prescribing practice.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded daily to ensure the medicines were being kept at the correct temperature. Records were kept whenever any medicines were used alongside notes in patients records.

We were shown the safety checks carried out in relation to prescriptions being issued. The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by GPs were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. At the end of the day we were told these are locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient. A receptionist told us they monitored the repeat prescription box for prescriptions which had not been collected on a monthly basis and notes placed within patients records.

Cleanliness & Infection Control

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

Good

Are services safe?

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

We saw staff had received infection control training; all staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities. Reception staff had access to gloves and alcohol gel if required when receiving samples from patients. We noted spillage kits were readily available behind reception.

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

A cleaning company were contracted by the practice to carry out cleaning including deep cleaning. We saw there was a cleaning schedule in place. This detailed what cleaning would be carried out on a daily, weekly, monthly and less frequent basis which incorporated deep cleaning. The cleaning company audited the cleaning and the office manager carried out spot checks on different areas of the practice to ensure everything was in order.

We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

One of the nurses had recently taken the lead for infection control and was looking to implement the recommendations not already completed from the external infection control audit carried out by Trafford CCG in November 2013.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment, this included the defibrillator and oxygen.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records for four staff. We saw recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that checks had been carried out with the disclosure and barring service (DBS) for all staff to ensure patients were protected from the risk of unsuitable staff.

Safe staffing levels had been determined by the practice for both clinical and support staff and rotas showed these were maintained.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. All identified risks were recorded and assessed. The office manager ensured action was taken to reduce any of the identified risks, and all information was disseminated to staff during meetings.

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

Good

Are services safe?

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

Arrangements to deal with emergencies and major incidents

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

We saw fire safety checks were carried out and full fire drills had been carried out. This ensured that in the event of an emergency staff were able to evacuate the building safely.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in dealing with medical emergencies including CPR.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains. This included calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation, referring to recent incidents in which emergency procedure were put in place following on-site medical emergencies. We were told following any medical emergency staff were involved in a debrief session.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners, Staff had access to a library or medical journals and text books with which they could refer as well as online tools such as 'Map of Medicine.' GP's discussed how they utilised these resources to provide evidence based care and treatment for patients, and referred to these resources where they had complex or new conditions which required care and treatment.

We saw minutes of practice meetings where new guidelines were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

We found from discussion with GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We were provided with a number of examples where the practice had made changes to the care and treatment of patients in line with update guidance from NICE including management of patients with diabetes and asthma.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for example management of respiratory disorders. The practice proactively engaged in research and clinical studies to inform good practice and looking at new ways to improve outcomes for patients. We saw the practice was involved in the Salford Lung Study and an Asthma study. As a result of the Salford Lung Study patients have access to thorough medical reviews, holistically and not just from a respiratory aspect, alongside up to date relevant investigations. Patients involved in the study were vigilantly monitored and reviewed regularly in order to enhance/ facilitate their respiratory condition and prevent acute exacerbations, initial results show a positive impact on patients experiencing episodes of exacerbations. Early results from patients taking part showed of the 28 patients taking part, only 11 had an episode of exacerbation since joining the study.

Speaking with the practice nurses they explained to us how they reviewed patients with chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) on an annual basis. We saw from The National Quality Outcome Framework (QOF) patients with diabetes had received appropriate tests and treatment and those patients with atrial fibrillation were being treated with anti-coagulation drug therapy or an antiplatelet therapy. We saw 100% of patients newly diagnosed with diabetes, had a record of being referred to an education programme to support them in managing their condition. The practice monitored the number of patients referred and recorded when patients did not attend to follow up at their next appointment.

The practice had developed joint GP and nurse 50 minute appointments for diabetic patients annual reviews to ensure their care and treatment needs were being met. To date the practice had completed 86% of reviews. Results showed positive outcomes for patients following the introduction of these clinics with the QOF data showing the practice were above local and national average outcomes.

The practice maintained a register of patients with a learning disability to help ensure they received the required health checks. We noted all patients' with learning disabilities had access to annual reviews with a nurse who had a special interest in learning disabilities, using the nationally recognised template. We saw 27 of 30 patients had had their formal annual reviews with eight having a written plan in place; the others had declined a written plan.

The QOF provided evidence the practice were above local and national averages when responding to the needs of people with dementia, including those newly diagnosed with dementia. For those patients with dementia 88% had their care reviewed in a face-to-face review in the preceding 12 months. For patients with poor mental health data showed 90.9% of those diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the records.

Good

Are services effective?

(for example, treatment is effective)

We saw from QOF 100% of child development checks were offered at intervals that were consistent with national guidelines and policy. To date 82% of children had attended plus those who had already had checks prior to joining the practice.

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

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

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held quarterly and minuted with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patient's physical and emotional needs.

For patients nearing the end of life care plans were in place. For those patients nearing the end of life but not imminent, their wishes were recorded and reviewed by the lead GP, with changes communicated and shared with out of hour providers. The practice promoted death at home where this was a patient's wish, and put in place support for this. All deaths were reviewed and recorded at palliative care meetings, including if patients choice had been maintained.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or chronic obstructive pulmonary disease (COPD). A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

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

The practice was making use of clinical audit tools and engagement in research and clinical studies to improve outcomes for patients. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where outcomes could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. We saw from the results of the Chronic kidney disease (CKD) audit and diabetes audit, improvements had been made to the number of patients receiving appropriate tests as recommended by NICE achieving For example as a result of the CKD audit seven patients were noted to have anaemia and were seen in the practice for further tests and treatment and within the diabetes audit it was noted as a result, patients diagnosed of pre diabetes had risen as a result of clinicians' raised awareness. The improved diagnostics and appropriate coding within patients notes was in line with NICE guidance.

One GP provided a free acupuncture clinic for patients with various conditions such as muscular-skeletal conditions, migraine, fibromyalgia and chronic fatigue syndrome. Completed audits showed a 70% response rate with reduced referrals to secondary care and a reduction in prescribing costs

The practice actively used the information they collected for the Quality and Outcomes framework QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. Patients with multiple long-term conditions were provided with one-stop reviews for all areas following appropriate investigations.

The practice ensured childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 98.5% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination, above the CCG average. Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 99.6% of outcomes achieved.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities (93% completed). For patients with chronic diseases such as COPD 94% of reviews had taken place and patients on long term medicine, for example 86% of patients with depression had had medications reviews at the time of our inspection. The practice had a proactive recall system in place for patients with chronic disease with a dedicated member of the administration team arranging recall appointments or home visits and prioritising vulnerable patients and those patients with poor mental health. They did this by extending the re-call system from a single letter, to phone calls and texts or carrying out reviews opportunistically when patients visited the practice.

Patients told us they were happy that the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

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

We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support, safeguarding and infection control. Staff were supported to complete additional training and gain additional qualifications, this included the office manager undertaking ILM L5 Leadership & Management training and a new apprentice was working towards NVG 2 business administration.

A good skill mix was noted amongst the GPs, where we saw a range of specialist skills including urology, women's health, mental health, diabetes and acupuncture. Patients had an option of seeing male or female GPs. The nursing staff had additional qualifications which included family planning and nurse prescribing.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list).

The practice manager had a training matrix in place so they could see at a glance what training each staff member had had and when it needed to be updated. Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice.

The practice had a system for supervision and appraisal in place for all staff. All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs were identified. All staff were aware of the values underpinning the practice and these new values were to be embedded as key performance indicators as part of the appraisal process. All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates.

Working with colleagues and other services

We found the GPs, nurses and health care assistants at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients.

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. It had been recognised that there was sometimes a delay in formally receiving hospital discharge letters. The practice had implemented a system to monitor patients they knew were in hospital and proactively check if they had been discharged, rather than wait for formal notification. This helped to ensure that home visits, update appointments and reviews to medicines could be done in a timely manner.

Quarterly multi-disciplinary meetings arrange by the practice were held with other health and social care professionals these included safeguarding and cancer/ palliative care review to ensure continuity of care and all relevant professionals were kept up to date.

Good

Are services effective?

(for example, treatment is effective)

The practice worked with associated health professionals including midwives, district nurses, community matrons, Macmillan nurses and phlebotomists. The community drug and alcohol team provided weekly clinics at the practice for patients, and joint reviews of patient care was carried out between a GP and the drug or alcohol worker to provide continuity of care.

Practice staff worked alongside learning disability teams in both Trafford and Manchester to meet the needs of their patients. Staff undertook learning disability specific training provided by the local authority disability team.

Information Sharing

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

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers (OOH).

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Regular meetings were held throughout the practice. These included all-staff meetings, clinical meetings, partner meetings and significant event meetings. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions. The practice manager and at least one GP attended all CCG meetings and one GP was the lead of the locality group and federation director. Information and learning from those meetings was fedback to all partners and where appropriate staff during meetings

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

Consent to care and treatment

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

For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up policy and procedures and templates were available to help staff, for example with making do not attempt resuscitation orders or best interest decisions. This policy highlighted how patients should be supported to make their own decisions and how those should be documented in the medical notes.

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations. A consent form was in place for staff to complete and included details of where a parent or guardian signed on behalf of a child.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person's understanding of the proposed treatment and consequences of agreeing or disagreeing with the treatment. The practice had a Gillick competencies checklist for staff to refer to if they were unsure about the process to follow. Speaking with the practice nurses they routinely saw young people unaccompanied and used the Gillick competency to assess their understanding. Where capacity to consent was unclear they would seek guidance prior to providing any care or treatment.

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

We were told for patients where English was their second language, the practice had access to pre-bookable translation services or if required immediately a telephone interpretation service. One GP was able to interpret for patients in Arabic, Urdu & Guajarati. Staff had received

Good

Are services effective?

(for example, treatment is effective)

basic sign language training and a British sign language interpreter could be arranged if necessary. Staff told us friends and relatives were not used to interpret unless specifically requested by the patient. This was to ensure they were supported to provide voluntary and informed consent to treatment. This is in line with good practice to ensure people are able to understand treatment options available and give informed consent.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check. New patient assessments were done by the practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way.

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

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. We were told health promotion formed a key part of patients' annual reviews and health checks and included discussions and assessments of a patient's mental health.

The practice provided NHS health checks for patients aged 40-74 which aimed to keep people well for longer. This was a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check with a practice nurse and written care plans. The practice had also identified the smoking status of 90.6% of patients over the age of 16 and actively offered smoking cessation with 90.5% receiving intervention which was above the local CCG average.

The practice's performance for cervical smear uptake was 95.4%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

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

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). We saw from QOF 100% of child development checks were offered intervals that were consistent with national guidelines and policy. To date 82% of children had attended checks, plus those who had already had checks prior to joining the practice.

The practice introduced newsletter for patients with the first edition January 2015, which was available in the practice and included healthy lifestyle advice and information to help patients stay well during the winter months.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14, a survey of 198 patients undertaken by the practice's patient participation group (PPG) and the friends and family test. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 95% of respondents described their overall experience of this surgery as good and 94% said the last nurse they saw or spoke to was good at treating them with care and concern. The initial findings from the friends and family test which started in December 2014 showed out of the six responses, five patients selected that they would be extremely likely to recommend the GP practice to friends & family if they needed similar care or treatment and 1 selected Don't know.

We spoke with eight patients and reviewed five CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

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

We saw all phone calls from and to patients were carried out in a private office away from the reception and waiting area to maintain patient confidentiality.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private, they would speak with them in one of the consultation rooms at the side of reception. All the patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the national patient survey, 92% of respondents found the receptionists at this surgery helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of modesty sheets to maintain patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 91% of respondents said the nurse involved them; both of these figures were above the national average.

Patients we spoke with on the day told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Most patients found that they had been able to see their preferred GP. This was reflected in the practice satisfaction survey carried out in March 2014 in which 62% of respondents said they got to see a GP of choice within one week.

Patients we spoke with told us the GP and nurses were patient, listened and took time to explain their condition and treatment options. This was reflective of the results from the national patient survey in which 93% said the last GP they saw or spoke to was good at listening to them and 91% said the last nurse they saw or spoke to was good at listening to them.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 91% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as

Good

Are services caring?

appropriate, above the local CCG average. We saw care plans were also in place for patients at risk of unplanned hospital admissions and those aged 75 and over who were vulnerable.

Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act 2005 and the Children's Act 1989 and 2005.

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

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

Patient/carer support to cope emotionally with care and treatment

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

From the national patient survey 87% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern and 94% said the last nurse they saw or spoke to was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the CQC comment cards we received were also consistent with this survey information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required. We observed all staff engaging with patients on the day of our inspection.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team. Patients and their family members who had recently been bereaved would be contacted by a GP and where necessary a GP would carry out a home visit or invite relatives into the practice. Patients were also provided with a booklet from Trafford carers with information on bereavement and where required referrals were made to Trafford bereavement service.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had an understanding of their patient population, and they engaged with the Clinical Commissioning Group (CCG) for Trafford and Manchester and the Patient Participation Group (PPG) to discuss local needs and service improvements that needed to be prioritised. The practice elected to provide additional enhanced services to help meet patients' needs for example opening extended hours, facilitating timely diagnosis and support for people with dementia scheme and a learning disabilities health check scheme. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice reviewed data to establish which patients groups were not attending appointments and annual reviews. It had been identified those not attending were often the most vulnerable patients. As a result the practice were proactive in contacting patients who failed to attend annual reviews, vaccination and screening programmes, especially those vulnerable patients who regularly failed to attend appointments. The practice appointed a member of the administration team whose role it was to re-call patients and contact those who did not attend, using various methods which included text messaging and telephone calls. They also used opportunistic opportunities for example, if a patient attended to see a drugs or alcohol worker, they would arrange for a practice nurse to be available at the time of the appointment and offer vaccinations and or reviews.. We saw from audit results, actively targeting patients and looking at how patient information was coded had had a positive impact; for example 95% uptake rate of cervical screening which was above average for the CCG. The practice was proactive in working with patients and families, in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice were proactive in supporting the needs of non English speaking patients, providing them access to face to face interpreters or telephone interpretation and for those patients who spoke Arabic, Urdu & Guajarati one the GPs was able to provide interpretation.

The practice was proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments. Home visits were provided by GPs, nursing staff and health care assistants.

We saw where patients required referrals to another service these took place in a timely manner. A peer review system took place with neighbouring GP practices with a current focus on referrals to secondary care; the results of the peer review showed the practice was consistently providing high quality referrals.

A repeat prescription service was available to patients, via the website, a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a proactive and diverse membership of the Patient Participation Group (PPG) with 15 active members. The PPG met formally on average every six months with regular contact via email in between meetings. We met with one members of the PPG who were positive about the practice and told us they felt welcomed and involved in its development. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example easier access to same day appointments and better communication with patients such as a newsletter.

The PPG met on a regular basis to review the findings from surveys and to discuss ways in which patient experience could be improved. Following the survey in 2014 we saw an action plan to address issues raised which included triaging of patients' needs and reducing the number of patients who did not attend for appointments.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice was on one level, was accessible for patients with disabilities and had disabled parking spaces available. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. However we observed one patient accessing the practice using a wheel chair experienced difficulty. We discussed this with the practice who informed us there was a help button located externally, however when we looked this was not clearly labelled. The practice told us they would address this immediately. A disabled toilet was available as were baby changing facilities.

The practice ensured that for patients where English was their second language they had easy access to an interpretation service. Information was available in different languages, accessed via the website.

The practice provided extended appointments where necessary and appointments were available early morning on Tuesday from 7am and Friday from 7.30am enabling people to make appointments out of normal working hours.

Access to the service

Appointments were available 8:00am and 6:30pm Monday, Wednesday and Thursday, 7:00am to 6:30pm Tuesday and 7:30am to 6:30pm on Friday. The practice had proactively reviewed the appointment system carrying out an audit of how and when urgent and routine appointments were being booked. As a result they planned to introduce more urgent appointments at the times required such as the beginning of the week and more routine appointments where the demand for urgent appointments was lower. We saw children and vulnerable patients would be seen on the same day with those most vulnerable patients having alerts placed on the computer system to ensure reception staff knew to prioritise same day appointments and or contact with a GP.

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

Patients were able to make appointments in advance by telephone or online via the practice website. For same day urgent appointments patients could telephone the practice to get an appointment where reception staff would, with consent, take brief details as to the nature of the appointment. Where appropriate they may request a call back by a GP before an appointment was provided as a telephone consultation maybe more appropriate. Where all appointments were filled, details were passed onto the on call GP for a telephone consultation and if required appointments would be offered at the end of surgery.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes and a GP would contact care homes prior to the weekend to see if any residents required GP services as a means of preventing unplanned admissions to hospital on a weekend. Home visits were provided to those housebound patients by GPs and nurses for both urgent and routine conditions and annual reviews.

The practice's extended opening hours 7:00am on Monday and 7:30am on Friday were particularly useful to patients with work commitments and were popular with those patients who commuted from a nearby tram service.

The patients we spoke with were satisfied with the appointment system. We saw from the national patient survey 90% of respondents found it easy to get through to this surgery by phone, 95% said the last appointment they got was convenient and 86% of respondents were satisfied with the surgery's opening hours above the local CCG average.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw there was a complaints procedure in place. We reviewed the complaints register which included verbal and written complaints and looked at a sample of written complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

The practice carried out an annual review of complaints to detect themes or trends over the year to learn and improve services. We looked at the report for the last review and saw the main complaints were with regards to communication and administration. From this the practice had implemented customer service update training. The review of complaints was also a formal agenda item for the patient participation group.

Complaints information was displayed and available on the website and within the practice leaflet. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

A comments and suggestion box was available for patients to provide on-going feedback and the 'Friends and Family test' was available for patients to complete via the practice website or questionnaires available in the waiting area.

The practice had a robust system in place to investigate concerns, with meetings held to discuss issues arising from complaints and incidents. We reviewed the log of serious incidents and concerns recorded over the past twelve months and found these were fully investigated with actions and outcomes documented and learning cascaded to staff and shared with other stakeholder where appropriate such as the CCG and Local Authority.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice had reviewed their vision and strategy following the retirement of two partners, actively involving all staff, which included a vision meeting for staff. As a result the practice identified seven core values which included professionalism, honesty and integrity. We saw the values displayed within the practice and staff were able to communicate these to us. We found details of the vision and practice values were part of the practice's strategy, business plan and formed part of staff key performance indicators.

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

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held management meetings and monthly primary health care, significant event and safeguarding meetings attended by clinical staff and managers. These incorporated multi–disciplinary meetings with external health and social care professionals where required for example safeguarding and cancer/palliative care reviews. All staff attended the significant review meetings as a means of communicating and sharing learning. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice worked closely with the Clinical Commissioning Group (CCG), with the practice manager forming part of the locality facilitation group and practice manager forum, with link to the Local Medical Committee (LMC). We noted one GP always attended the CCG full council meetings held quarterly and one of the GP partners was the lead of the locality group who met bi-monthly to discuss issues affecting practices across the locality such as increased patient population due to new housing developments. One GP is also a federation director for Trafford Primary Health (TPH) alongside three other directors representing different localities. We were told this new venture would enable practices to bid for funding and Out of Hours contracts in the future.

The practice used the range of data available to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed that in 2013/14 they had met 99.6% of the outcomes, above the local CCG average. The practice had appointed an administrator to help achieve the outcomes for patients with an emphasis on supporting vulnerable patients. For example data showed the practice had a higher than CCG average for exception reporting for a number of clinical conditions such as Asthma. In 2013/14 the practice achieved 100% of QOF outcomes for asthma with 81.1% of patients attending annual asthma reviews which were above the local average. The practice was above average for all clinical outcomes, including mental health and learning disabilities where they were well above the local average.

The practice had a full clinical audit system in place to continually improve the service and deliver the best possible outcomes for patients. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of completed audits. These included clinical and non clinical audits such as a phone call audit to inform the practice appointment system. Clinical audits included cervical screening, identifying patients at risk of diabetes and screening for renal anaemia for patients with Chronic kidney disease (CKD). We saw from the results of the CKD audit and diabetes audit, improvements had been made to the number of patients receiving appropriate tests as recommended by NICE achieving 100% of QOF outcomes for CKD and diabetes. We saw from all audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during team meetings.

Are services well-led?

Outstanding ☆

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

A peer review system took place with neighbouring GP practices with a current focus on referrals to secondary care; the results of the peer review showed the practice were consistently providing high quality referrals.

From the summary of significant events we were provided with and from speaking with staff we saw learning had taken place and improvements were made.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Boundary House has been accredited by Investors in People (IIP) standards since 1999 and following a review requested by the practice after significant changes to staffing and GP partners in 2014 they were found to be maintaining standards and were again accredited by IIP.

Leadership, openness and transparency

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

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

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

All staff had an appraisal meeting, giving staff the opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. All staff we spoke with confirmed they had had an appraisal and the nursing staff told us they had joint appraisals with the practice manager and a GP. GPs also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, PPG surveys, suggestion box, compliments and complaints.

We saw that there was a detailed complaints procedure in place, available for patients in the waiting area, practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the national patient survey carried out in 2013/14 and noted 95% describe their overall experience of the practice as good. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services) We saw in December 2014 out of a total of six responses, five patients selected that they would be extremely likely to recommend the GP practice to friends & family if they needed similar care or treatment and 1 selected Don't know. All comments were extremely positive about the care and treatment patients had received.

The practice had a Patient Participation Group (PPG) which was made up of a diverse range of patients. The PPG meet on a regular basis to review the findings from surveys and to discuss ways in which patient experience could be

Are services well-led?

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improved. We were provided with the analysis of the last patient survey and an action plan, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice made available to patients a newsletter, providing patients with updates such as changes to appointments, repeat prescriptions and healthy lifestyle advice such as the smoking cessation service.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

Peer support and team work were evident throughout the practice and staff had access to regular formal appraisals and supervision. From staff records and speaking with staff they told us they regularly attended training courses. Mandatory training was arranged for staff and they were able to request relevant training courses that would enhance their performance at work. We noted the office manager was participating in ILM L5 Leadership & Management Training and nursing staff had been supported to achieve additional qualifications. Clinical staff told us they were supported to maintain their continual professional development (CPD). Staff told us they felt very well supported at work and that the practice had an open door policy so they could raise any concerns.

The practice was a GP training practice with two GP specialist trainees. Speaking with the trainees and looking at past evaluations the feedback with regards to the support and learning opportunities provided by the practice was positive. We noted that four of the current GPs at the practice were previously trainees and the practice were proud of the training they provided GP specialist trainees.

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