Hope Citadel Healthcare CIC

Quality Report

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Date of inspection visit: 5th March 2015
Date of publication: 28/05/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hollinwood Medical Practice on 5 March 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing caring, responsive, effective and well led services. They were outstanding for providing services to most of the population groups, specifically those who were vulnerable. We also found that safe services were 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. 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.
- 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 in many innovative ways to help patients understand the care available to them.
- 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 multi-skilled staff and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and patients who found had difficulties understanding, were encouraged to complain verbally and supported in the process.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

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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:

- The practice had increased the flexibility and length of time of their appointments to 13 minutes instead of ten and could demonstrate the impact of this by reduced use of the accident and emergency services and positive results from clinical audits.
- The practice had a very good skill mix which included a nurse prescriber, counsellors and rehabilitation workers and was able to provide social and medical care for a focussed range of patients. They were able to demonstrate the positive impacts for this group of patients.
- The practice attended the primary schools in the area three times a year, drug and alcohol rehabilitation units and hostels to promote better health. If underlying health issues were identified patients (if they did not have a GP) were offered the opportunity to register with the practice. If they were known to the practice they were encouraged to attend for an appointment.
- The practice organised social activities such as car boot sales, open days, "come and eat cake" days and food parcels for patients in need. They were also planning parenting classes, boogie babies and a choir. They did this to build relationships with the patient population, increase awareness of what the practice offered and reduce inappropriate attendance at other services such as walk in centres or accident and emergency departments.
- Through their care and treatment of chronic obstructive pulmonary disorder (COPD) the practice had identified areas within the county where COPD was higher and people required treatment. They had shared this information with the CCG and were working to reduce the effects of this condition throughout the community.
- All staff undertook annual 360 degree feedback and appraisals that identified learning needs, from which action plans were documented. 360 Degree Feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.
- Verbal complaints were encouraged to assist people with reading or writing difficulties and staff recorded these in full.

There were some areas where improvements should be considered.

Importantly the provider should:

- Introduce a system of management responsibility for each day's workload to ensure that nothing is missed at the end of each day.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and 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?

Outstanding

The practice is rated as outstanding for 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 (NICE) 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 neighbouring practices in the Clinical Commissioning Group (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?

Outstanding

The practice is rated as outstanding 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 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 patient's 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

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delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the Local Area Team and 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 and all its staff shared a clear vision to deliver high quality care which covered the dynamics of the whole person, their families and their surrounding environment. There was a clear leadership structure with named members of staff in lead roles who helped to lead and mentor the practice staff. Policies and procedures governed high standards which were promoted and owned by all practice staff. Staff undertook annual 360 degree feedback and appraisals that identified learning needs which were addressed. Significant events were reviewed regularly and staff were supported when things went wrong with a “no blame” culture. Patients, public and staff were encouraged to provided feedback which was acted upon. Governance and management arrangements were proactively reviewed and took account of current models of best practice. There was a high level of engagement and satisfaction from all staff.

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 care of older people. Nationally reported data showed that outcomes for patients were high for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. The practice offered planned and unplanned home visits and rapid access appointments. Clinical staff were educated and mindful about polypharmacy issues including possible interactions, compliance issues and national guidelines. They worked closely with pharmacies, encouraging dosette boxes where required to reduce error. (Polypharmacy is the use of multiple medicines in the elderly). Christmas parties and hampers were arranged by the staff at the practice for the local supportive housing and the practice worked in partnership with the University of the Third Age which gives over 65s the opportunity for learning and activity. They also worked closely with Age Concern and social care services. These activities encouraged relationships and decreased isolation in older people.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. GPs and Nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice were able to evidence that prevalence gaps were closing through their active screening and case finding. Some staff members with specific interests received additional training.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were a large number of children with complex needs on the practice list cared for under Direct Enhanced Services (DES). This meant they had a named GP and increased access. Care plans were in place for a large majority of complex families and the practice worked closely with the Children and Adolescent Mental Health Services (CAMHS), community paediatricians and secondary and tertiary care. One of the GPs had

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a special interest in paediatrics and families with complex needs. Staff were given contraceptive and implant training and helped educate patients to reduce unwanted pregnancies. Health advice and education was provided in local primary schools three times a year. The practice had a multidisciplinary team approach for the care of the many families within the community where complex social issues affected their physical and mental health and were able to evidence positive outcomes.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice worked with Christians Against Poverty (CAP) to provide support with debt and money matters and focussed care workers assisted families with housing issues and the completion of documentation. Patients with difficulty reading and/or writing were encouraged to provide feedback, complaints and comments verbally and these were all logged and dealt with. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. They held registers of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. A focussed care service carried out assessment of the needs of whole family units, reviewing the impact of health, social and welfare issues affecting one or more of them. Patients on the focussed care caseload had intense intervention from multi disciplinary workers employed by the practice and, when support could be reduced or stopped, they were discharged back to the normal practice caseload. Data was consistently audited and reviewed to show the benefits of the service and we saw extreme positive outcomes for a high number of patients. Asylum seekers, homeless and travellers had all been accepted onto the patient list and the practice was pro-active in encouraging these patients to the practice and educating them in the services available rather than A&E. They did this by working with probation services, the local probation hostel and safe houses for women in violent relationships. They

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encouraged vulnerable people into activities within the community such as choirs, churches and voluntary sectors. They provided assistance and support with paperwork for appeals and financial issues and access to food banks.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). A high number of people experiencing poor mental health had received input from the practice. Patients with mental health problems had care plans and access to drug and alcohol services within the practice. A Benzodiazepine reduction clinician worked with patients to reduce their addictions. The practice offered counselling and CBT services and had good links with mental health services and crisis teams. Staff were trained to recognise mental health presentations and enable access. A resource list had been developed to support mental health work, including living life to the full. Audio and visual resources had also been made available. The practice had undertaken a dementia audit which had highlighted patients coded incorrectly. All dementia patients within the practice list had now been identified and were offered and receiving services available to them such as referrals to memory clinics for assessment and care.

Summary of findings

What people who use the service say

We were able to speak with 12 patients on the day of the inspection, one who was a member of the Patient Participation Group. All were very complimentary about the service and the staff. We received 15 CQC comment cards most of which were very positive about the service and the staff.

Some patients reported that they were finding it harder to get routine appointments as the practice grew and some patients found it difficult to see the same GP. We looked at the results of the 2015 GP patient survey which is an independent survey run by Ipsos MORI on behalf of NHS England. 98% of respondents said the last appointment they got was convenient and 89% said they usually got to see or speak to their preferred GP.

All the patients we spoke to reported positively about the practice and in particular about the staff. They said they were regularly advised on lifestyle issues. They said there was excellent care, a friendly atmosphere and they felt listened to, supported and safe. In particular patients reported kindness and inclusion by staff despite some very challenging issues.

Of the patients who responded to the national GP patient survey 99% had confidence and trust in the last GP they saw or spoke to and 98% said the last nurse they saw or spoke to was good at listening to them.

Areas for improvement

Action the service SHOULD take to improve

The practice should introduce a system of management responsibility for each day's workload to ensure that nothing is missed at the end of each day.

Outstanding practice

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is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

- Verbal complaints were encouraged to assist people with reading or writing difficulties and staff recorded these in full.

Hope Citadel Healthcare CIC

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 Adviser, a practice manager specialist adviser and an expert by experience. An expert by experience is someone who has used health and social care services.

Background to Hope Citadel Healthcare CIC

Hollinwood Medical Practice opened in January 2010 and is one of four GP practices in Greater Manchester run by Hope Citadel Healthcare CIC. Hope Citadel Healthcare CIC was set up with the aim of providing NHS services to those in under-doctored and deprived areas. They are a not-for-profit community interest company and offer whole person healthcare which they refer to as 'focussed care'.

They have been commissioned by the Clinical Commissioning Group (CCG) under an Alternative Provider Medical Services (APMS) contract. This enables them to deliver services through a wide range of providers specifically tailored to the needs of the local population. The practice work with their in-house counsellors, community nursing team and other external organisations such as the local council, social care and community matrons to help with health and social care issues within the community.

The practice is open on Monday and Thursday from 8am until 7pm, on Tuesday and Wednesday from 8am until 8pm and on Friday from 8am until 6pm. On a Saturday they are open from 1pm until 5pm. They have increased the length of each appointment from 10 minutes to 13 minutes which patients have reported as positive..

When the practice opened in 2010 they had a zero list size which has grown to in excess of 3,000. The service is located in a considerably deprived area with a very diverse population. In August 2014 they moved to new purpose built premises and have encouraged more people in the community to access services. The practice should continue to review the access for patients so that the existing service is not diluted by the increase in the patient population

Patients have access to two male and two female salaried GPs, two nurses, a health care assistant, two counsellors and a focussed care co-ordinator (all female) who work part time. A part time practice manager, three part time administration staff and two full time reception staff manage the day to day running of the service. The practice helps to train GPs by accepting Foundation Year doctors and medical students. They do not currently have a trainee in position but a trainee is expected in August 2015.

There is a board of directors and a non executive board of trustees (all voluntary) who manage and support the staff over the four practices.

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.

Detailed findings

The practices have opted out of providing out-of-hours services to their own patients. Advice on how to access out of hours services is clearly displayed on the practice website and over the telephone when the surgery is closed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008. 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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 March 2015. During our visit we spoke with the practice manager, administration and reception staff, three GPs, the medical director and the company director and other clinical and nursing staff. We also spoke with 12 patients who used the service. We observed how people were being cared for and reviewed information provided by the practice and CQC comment cards where patients had shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information such as a significant event logs, the accident book, the complaints log and comments received from patients and staff to identify risks and improve patient safety. Incidents and national patient safety alerts as well as comments and complaints received from patients were recorded over time. All staff were encouraged to report anything they considered an adversity. The staff we spoke with were very aware of their responsibilities to raise anything outside the ordinary. They knew how to report incidents and near misses and all data was recorded on a spread sheet which was overseen by the practice manager. A recent incident referred to a letter which had not been sent following a patient consultation and this had been shared and learned from.

We reviewed significant events over the last three years, complaints over the last twelve months and the accident book as well as minutes of meetings where these had been discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. Records over the last three years showed a number of incidents recorded and these were given a rating to show the level of impact. Levels ranged from no impact to near miss. We saw over 400 data items recorded over a three year period, only five of which were major (near miss) and two which were moderate. The rest had a low or no impact rating.

We saw evidence of action taken such as a change in working practice or added supervision for a member of staff following an incident. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. There was a “no blame” culture with emphasis on system faults and not individual staff members.

There was a GP responsible for the collation of national patient safety alerts which were disseminated at the monthly clinical meetings to relevant staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for such as the prescription of a medicine for patients with a high risk of coronary heart disease (CHD).

Reliable safety systems and processes including safeguarding

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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice’s electronic records. Children with child protection concerns had a code which identified them in their electronic record. Most safeguarding referrals were done through the focussed care lead who in conjunction with the lead GP, was safe-guarding lead for the practice. Concerns about any existing vulnerable patients and new concerns were managed through the focussed care team and the focussed care team worker had a caseload currently of approximately 40 patients. Multi-disciplinary safeguarding meetings were attended by the focussed care team worker

who was also encouraged to attend clinical meetings within the practice and share information. Children's attendance at accident and emergency was monitored and patient lists and registers were used to keep track.

We saw a chaperone protocol in place which was visible in the waiting room and in consulting rooms. Nurses, the health care assistant and administration staff were called upon to act as a chaperone if and when required. (A chaperone is a person who acts as an advocate for a patient and health care professional during a medical examination or procedure). All staff undertaking this role had read the protocol and had been given training at their induction by the Director of the Company.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice held a stock of one controlled emergency drug (controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse). Checks were being followed by the practice staff and the controlled drug was stored in a locked cupboard with the emergency medicines and access to it was restricted and secure.

The practice used the clinical system to manage repeat prescription requests which were listed daily for one of the GPs to deal with. Prescriptions were authorised by the GPs and a recently qualified nurse prescriber. A prescribing policy existed across all four practices under the management of Hope Citadel Limited and staff were aware of the policy and what it entailed. Medicine reviews took place during patients' birthday months each year by a GP.

The practice accepted input from the CCG's medicine management team and we saw a history of attendances. We saw that audits were undertaken regularly and any warnings, anomalies or changes that could be made were passed to the practice manager to disseminate. All medicine information was discussed between the GPs at clinical meetings and we saw details with actions taken when necessary. For example all patients taking Thiamine (a form of Vitamin B) were identified and screened to see if they should continue taking the medicine or if there were contraindications because of their illness. High antibiotic prescribing was identified and attributed to a high number of patients with exacerbations of chronic chest infection. The practice followed the CCG prescribing formulary for these patients.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The premises were cleaned and maintained by a specific cleaning company and we saw details of checks undertaken by the manager of that company to ensure the premises were kept clean. The cleaning company manager and the practice manager had a good relationship and liaised regularly to resolve any issues that might be found. However there was no checklist to record what had been cleaned on a daily basis to ensure that the spread of infection was protected and controlled. For example the waiting room contained toys which were handled by children daily and there was nothing to evidence how and when they were last cleaned. We saw a good stock and supply of all the appropriate cleaning materials and mops and buckets which were appropriately colour coded.

Couches in treatment and consulting rooms were protected with paper towels and curtains were disposable. Nurses and clinicians were responsible for keeping their own areas clean. All the rooms we saw were clean, appeared visually clean and were free from clutter. Notices

about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Minutes of practice meetings showed that infection control updates were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Equipment

The clinical staff told us they had all the necessary equipment required to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration and servicing of relevant equipment that included blood pressure monitors, spirometer, weighing scales and the vaccines fridges.

We also saw that fire alarm was regularly tested, checked and serviced. There were also checks of fire extinguishers.

Staffing and recruitment

Most of the staff had worked at the practice for a number of years. There was a recruitment and selection policy that set out standards it followed when recruiting clinical and non-clinical staff. This included plans for induction when new staff were recruited.

Staff generally felt there were enough of them to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe. The practice population was growing rapidly and the managers and leaders had acknowledged that an increase in staff was required to ensure the service currently provided was not diluted. Reception staff reported that more staff would improve services for patients.

The practice manager showed us records that demonstrated actual staffing levels and skill mix were in line with planned staffing requirements. The company were responsible for practices within the area and staff from other practices could be utilised for cover during sickness or holiday leave.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring safety and 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated with mitigating actions recorded to reduce and manage the risk. For example, when a lightning conductor cable had been dislodged from the roof of the premises we saw that this had been identified as a risk and reported to staff and patients.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long term conditions and specifically patients who became acutely ill or went into crisis due to their physical wellbeing or mental health conditions. They would be referred to the focussed care team of the practice and receive intense input until their condition had stabilised and they could be discharged back to the regular practice caseload. The practice were able to evidence reduced referrals to other services such as

accident and emergency departments, social services, counselling and housing or welfare assistance. Waits for patients were reduced and positive outcomes were achieved sooner.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately. Emergency scenarios were frequently played out so that staff knew what to do in the event of an incident.

On the day of the inspection we saw how the practice staff managed an emergency situation when a patient became ill. The staff knew what action to take, were calm and efficient and looked after the patient and their partner with care until an ambulance arrived to take them to hospital.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. Implications on practice performance and patients were discussed and required actions were agreed. We saw that the actions were designed to make sure that each patient received the support required to achieve the best health outcome for them. We saw that GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had a focussed care approach which mirrored the Gold Standards Framework. They undertook intense needs assessments on patients, specifically those in crisis and provided the health, social and welfare support required rather than signposting to other services. Data showed that this service reduced attendance at accident and emergency departments and other welfare and counselling services. The practice was involved in a direct enhanced service (DES) to avoid unplanned admissions to hospital and had done anticipatory care plans for complex patients. Some of those had been completed by the community matron and shared with the practice. All plans were shared with out of hours services and any other services involved in the patient's care.

GPs led in specialist clinical areas such as dementia, focussed care, mother and baby checks, kidney disease and Quality and Outcome Frameworks (QOF). Clinical staff told us they met regularly to share learning and continually reviewed and discussed new best practice guidelines. Review of clinical meeting minutes confirmed that this happened.

Quality meetings between the practice manager and GP lead took place to discuss QOF and any action they could take to provide better services or increase performance. The Medical Director of the company showed us data about the practice's performance in the care of chronic obstructive pulmonary disorder (COPD) which had highlighted areas where COPD was higher and people required treatment. They had shared this information with the CCG and were working to reduce the effects of this condition throughout the community.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. We saw many examples of this, particularly with regard to the focussed care patients.

Management, monitoring and improving outcomes for people

To encourage patient engagement in a considerably deprived area the practice had created focussed care which acted like an outreach service providing whole person and family intervention. All the staff in the practice had key roles in monitoring and improving outcomes for patients. These roles included counselling, health promotion, family education and health and social care intervention. Non clinical staff were also heavily involved providing open days and fundraising events. A key number of patients with a poor view of national health services had been encouraged to access services and the practice staff had built trusting relationships to improve the dynamics of whole families. It was clear from data and information provided by the staff that positive outcomes had been achieved.

The practice celebrated the success of its patients, shared their stories on the practice website (with their consent) and encouraged others to make positive changes in their lives. Every year the practice gave out awards to patients that had brought about significant changes in their lives and those of their children.

The practice showed us three clinical audits that had been undertaken in the last 12 months. These were all completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Following the audits systems or treatment had been changed where required. A dementia audit had identified some patients incorrectly coded on the electronic record which meant they could be missing treatment of care available to them. Re-audit confirmed that all dementia patients were now correctly diagnosed and coded accordingly. All had been checked to ensure they received appropriate intervention. Clinical audits were linked to

medicine management information and safety alerts. Patients with a high risk of coronary heart disease had been identified and medicines with a negative impact on their condition had been reduced. GPs maintained records showing how they had evaluated services and documented the success of any changes.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where they could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical and nursing staff should undertake at least one audit a year.

Repeat prescribing which was in line with national guidance and staff regularly checked that patients on repeat medicines had been reviewed by the GP. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, counselling, care co-ordination, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual 360 degree feedback and appraisals that identified learning needs, from which action plans were documented. 360 Degree Feedback is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The health care assistant (HCA) told us how the practice had encouraged, supported and paid for her to obtain a degree. Nurses had training every three months and a mentor was provided for HCAs. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. There were no trainees at the time of inspection but the practice were expecting one in August 2015.

Practice nurses performed defined duties and were able to demonstrate that they were trained to fulfil these duties. They had received updates in the likes of administration of vaccines, cervical cytology, phlebotomy, diabetes and asthma. Most of the staff were included in extended roles within the focused care area of the practice. They were trained in conflict resolution, child protection, and working with people with addictions.

Working with colleagues and other services

The practice were pro-actively working with other services such as the community matron, social workers, pharmacy, probation services, benefit agencies and the local council. There were a number of complex children on the practice list who were cared for under enhanced services and the practice regularly worked with CAHMS (children's mental health services) and community paediatricians. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Practice staff attended common assessment framework (CAF) meetings to ensure that families in difficulty received the multi-agency input they required to support them. We saw many examples of positive outcomes for disadvantaged children and children at risk due to the intense support provided by the staff at the practice. They were also commissioned for the enhanced service to follow up patients discharged from hospital. There was a system to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held regular joint agency meetings to discuss the needs of complex patients, for example, families in crisis, those with end of life care needs or children on the at risk register. Those meetings were attended by the community matron, Oldham West district nurses, social workers and palliative care nurses. Care planning was documented and shared and staff felt the system worked well, improving outcomes for patients.

They 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. There was a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. No one person was in charge of managing the day's workload to ensure that nothing had been missed at the end of each day. We fed this back to the leaders who acknowledged that a responsible lead for each day would be more effective. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Information sharing

The practice used a number of electronic systems to communicate with other providers. These enabled them to share information about out of hours and accident emergency attendances in a secure way and referral data to be shared in a timely manner. Staff confirmed that these systems worked well and were easy to use. Printed summaries and care plans could be generated from the systems and were provided to community matrons or patients attending other appointments in an emergency. The practice were signed up to the electronic summary care record (giving patients the opportunity to opt out) and to electronic prescribing.

The practice had systems to provide staff with necessary information about each patient. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The medical director systematically reviewed the GPs clinical record-keeping to ensure clinical data was consistent and that records were kept up to date. An audit had recently been undertaken to make sure that all dementia patients were correctly coded.

Consent to care and treatment

Staff had an awareness of mental capacity and their duties in fulfilling it. No formal training around the Mental Capacity Act had been undertaken by any clinical or non clinical staff. However the consent policy included a section about mental capacity and directed staff to the Mental Capacity Act tool kit. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented in their practice. All staff had received training on how to recognise mental health presentations and enable access. Some patients had advanced directives and do not attempt resuscitation (DNACPR) plans in place.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw anticipatory care plans which had been reviewed frequently when circumstances had changed. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. Consent was requested for things such as photographing or video recording (which was carried out during some training exercises). These forms were completed and scanned into the patient's electronic record.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example they offered opportunistic cytology screening to females and weight management advice to patients who were over or underweight. The practice offered NHS health checks to all its patients over the age of 40.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Registers of children at risk, families in crisis and other vulnerable patients such as patients with a learning disability were kept at the practice. All these patients were offered annual physical health

Outstanding ☆

Are services effective?

(for example, treatment is effective)

checks. We were shown examples where weight loss and smoking cessation had created positive outcomes for patients. We also saw examples where health checks had identified life threatening conditions which may not otherwise have been identified and the patient had received urgent medical treatment.

The practice's performance for cervical smear uptake was up to 89% from 46% through the dedication of the staff within the practice. They reached out to the local community and built relationships with female patients with poor knowledge of the health implications if they did not have regular cytology screening. They promoted better health in the community by attending schools three times a year, local hostels and churches and through probation services. They had a dedicated community worker who helped to engage patients into the services available.

All patients with a body mass index over 35 were offered access to a service called 'choose to change'. Choose to Change is a specialist weight management service that helps adults make lifestyle changes that will enable them to lose weight and improve their health. The programme encourages life long changes and helps people to overcome their barriers to weight loss. Access to the service is via a GP, nurse or dietician and the practice staff provided additional support to patients using the programme if they requested it.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from the national GP patient survey 2015 showed that this practice scored much higher in some areas than other practices in the Clinical Commissioning Group (CCG).

89% of respondents with a preferred GP usually got to see or speak to that GP – the local average was 58%. 99% had confidence and trust in the last GP they saw or spoke to.

Consulting rooms were private, privacy was maintained in the waiting areas and staff followed confidentiality. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

The practice celebrated the success of its patients, shared their stories on the practice website (with their consent) and encouraged others to make positive changes in their lives. Every year the practice gave out awards to patients that had brought about significant changes in their lives and those of their children. Examples were patients who had freed themselves from domestic violence, given up drugs and alcohol, lost weight, stopped smoking, cared for a family member with dementia or simply attended school every day. The practice had been instrumental in bringing about these positive changes through their treatment and support.

Patients we spoke with said they felt the practice offered an excellent service and were efficient, helpful and caring. They said staff treated them with dignity and respect and were more like friends. The practice manager was very instrumental in the community and staff demonstrated their work as a vocation.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Staff made concerted efforts to build trusting relationships with some patients who might be intolerant of, or lack knowledge about, national health services. The care provided by the practice was very holistic and took account of public health determents such as employment or housing status which affected physical and mental health.

Care plans were in place for a large majority of complex families and the practice worked closely with the Children and Adolescent Mental Health Services (CAMHS), community paediatricians and secondary and tertiary care.

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. 89% felt the GP explained their treatment well and 94% felt involved in the decision making process.

Translation services and face to face translators were available for patients who did not have English as a first language and were used often due to the diversity of the population. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Data from the national patient survey showed 98% had confidence and trust in the last nurse they saw or spoke to and 94% the nurse was good at treating them with care and concern.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP or he community matron would frequently visit relatives. We saw examples where support had been given to patients.

The practice worked with Christians Against Poverty (CAP) to provide support with debt and money matters and focussed care workers assisted families with housing issues

Outstanding ☆

Are services caring?

and the completion of documentation. Patients with difficulty reading and/or writing were encouraged to provide feedback, complaints and comments verbally and these were all logged and dealt with.

The practice was in regular contact with the local supportive housing closely located to the surgery and the practice staff worked in partnership with the University of the Third Age which gives over 65s the opportunity for learning and activity. They also worked closely with Age Concern and social care services. These activities encouraged relationships and decreased isolation in older people.

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 were constantly screening and case finding through 'Fingertips' a system available to GPs, which gave them a clear overview of their performance and an insight into the possible health needs of the population that they served. They used this to plan what other services would be effective to their diverse population group and offered access to counsellors, cognitive behaviour therapy and a drug and alcohol reduction worker all who were able to identify and promote health and wellbeing.

The practice regularly engaged with the Local Area Team, the local council, the Clinical Commissioning Group (CCG) and other practices to discuss service improvements that needed to be prioritised. We saw data which had been shared and actions which were agreed to manage delivery changes such as new premises, increased appointment times from 10 to 13 minutes, double appointments for patients on the focussed care list and telephone triage slots.

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). The group asked for more information about services to be available in the waiting room and the practice responded by introducing notice boards and a television screen. A sexual health drop in clinic was also introduced so that local young people could have access to contraception and advice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Text messaging was introduced to encourage attendance at appointments and a resource list was available to support people living with mental health issues. Support was provided to vulnerable patients with financial issues including help with benefits and access to food banks. Food parcels were delivered and the practice organised social activities such as car boot sales and open days. A Christmas party was prepared and Christmas hampers were delivered to the local supportive housing scheme, situated next door to the practice. The practice were also planning parenting classes, boogie babies and a choir. They did this to build relationships and educate patients about what the practice and the NHS offered. They found this reduced inappropriate attendance at other services such as walk in centres or accident and emergency departments.

Equality and diversity training was encouraged through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises were suitable to meet the needs of patient with disabilities. There was plenty of room for wheelchairs, ramps and automatic doors were in place, there was a hearing loop if required and access to interpretation services.

The practice had registers of patients living in vulnerable circumstances and a system for flagging vulnerability in individual records. People were encouraged to register with the practice, including asylum seekers and those with no fixed abode.

Access to the service

The practice was open on Monday and Thursday from 8am until 7pm, on Tuesday and Wednesday from 8am until 8pm and on Friday from 8am until 6pm. On a Saturday they were open from 1pm until 5pm. They had increased the length of each appointment from 10 minutes to 13 minutes which patients had reported as positive and patients on the focussed care register were automatically given double appointments. The practice's extended opening hours at the weekend was particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Through the PPG patients had reported that they found it difficult to get an appointment and felt they were ringing back quite a few times before they were seen. The practice

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

had introduced a telephone triage system and reserved appointments specifically for urgent requirements. The surgery had seen an increase in the number of new patients registering and had increased appointments to help with the demand. Patients we spoke to confirmed they could generally see a GP on the same day if the needed to or could see another doctor if there was a wait for the one of their choice. Some patients reported that the rise in patient population had reduced access to the service.

Listening and learning from concerns and complaints

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

An information leaflet was available to help patients understand the complaints system and staff were also helpful and pro-active in obtaining complaints and comments. Verbal complaints were encouraged to assist people with reading or writing difficulties and staff recorded these in full. We saw details of the complaints log and noted that these were handled appropriately, in a timely manner and with openness and transparency. We saw that patients were offered apologies when necessary and that practice protocols or systems were changed as a result of complaints such as the introduction of added appointments to deal with patient demand.

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 a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice and all its staff were proud of the service they provided to patients and the work they undertook in the local community. They worked consistently to ensure that resources were delivered to the diverse population. They aimed to provide services that met the needs of the entire community and achieved this by delivering care which covered the dynamics of the whole person, their families and their surrounding environment.

We spoke with nine members of staff and they all knew and understood the vision and values of the company and their responsibilities in relation to them. Staff we spoke with said the practice was really special and everyone was signed up to the aims and objectives.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at more than 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. There was a board of directors with overall management of the company and a board of non-executive voluntary directors who helped to lead and mentor the practice staff. There were leads within the practice for infection control, safeguarding, dementia, focussed care and chronic disease and staff knew who they were. All the staff we spoke with were clear of their responsibilities to maintain patient care. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) and other systems such as Fingertips to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Patients with alcohol dependency had been screened to ensure they were receiving the correct medication. There were several systems for identifying, recording and managing risks which were regularly discussed at team meetings and updated in a timely way. Performance, quality and risks were discussed at team meetings.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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. We also noted that annual team away days were held.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies such as disciplinary procedures, induction policy and management of sickness which were in place to support staff. We saw the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through verbal comments and the friends and family test. We looked at the results of from patient participation group meetings (PPG) and saw that changes had been made as a result of feedback from patients. This included the building of an entire health centre. In addition the PPG were looking to set up a diabetes support group and to hold an open day for the over 50s to advertise services available in the local community. Patients were encouraged to use the website which offered an easy way of providing feedback to the service.

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

Are services well-led?

Outstanding ☆

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a 360 degree discussion and a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. There was also an annual GP study day and regular study leave for doctors.

The practice was a GP training practice and mentored medical and nursing students and also encouraged work experience to school leavers. A young apprentice with no aspirations started at the practice and was mentored into medical school within four years. A medical student was due to start with the practice in August 2015.

The practice reviewed their significant events regularly. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. There was a “no blame” culture with emphasis on system faults and not individual staff members.