West Gorton Medical Centre

Inspection report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Good** ●
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as Outstanding. This practice is registered at a new address.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? – Outstanding

We carried out an announced comprehensive inspection at West Gorton Medical Centre 2 Clowes Street, Manchester on 23 May 2018. The GP practice was located previously at address 6a Wenlock Way, West Gorton and was inspected on 21 July 2016 where we rated the practice Good with Safe rated as requires improvement for recruitment procedures and systems of staff appraisal.

This was the practice's first inspection at this registered location. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

At this inspection we found:

- The GP Partners were a driving force, united in their commitment to deliver person centred care to their patient population. They effectively used the skills and abilities of their staff team and the resources available in the local community to provide innovative and accessible care, treatment and support to their patients.
- All the practice team were passionate in involving patients in the management of their own health and wellbeing.
- The practice's underpinning ethos was that the patient was central to all its activities. It involved patients in learning and understanding about their health conditions to promote improved self-management and it utilised effectively community resources to ensure their patients received as much support as possible.
- The GPs worked closely with allied health and social care services to provide a holistic approach to the care provided to patients living in a deprived area.
- The practice implemented new approaches to patient engagement in the management of their long term health condition. Relationships were based on mutual respect and active involvement of patients in their own care by increasing education, promoting self-care and providing support with encouragement to lead healthier lives.
- The practice had clearly defined and embedded systems to minimise risks to patient safety and the practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patient feedback on the care and treatment delivered by all staff was overwhelmingly positive.

We saw areas of outstanding practice including:

- Systems to ensure children were safeguarded were supported by the practice's policy 'Child not brought to appointment', whereby all non-attendances at primary care and secondary care appointments were responded to and appropriate action implemented.
- The practice was proactive in piloting research based new ways of working with patients. This included holding regular planned group consultations with diabetic patients and weekly group drop in sessions for patients with chronic obstructive airways disease. Besides the health benefits of these group health care meetings, patients had the opportunity to develop social support networks outside of the GP practice meeting.
- The practice was proactive in seeking out support services and offering these locally for their patients. Supportive services available to patients included the regular contact from the health and wellbeing service Buzz Manchester, weekly visits by staff from the Citizens Advice Bureau and joint working with Shared Care to provide personalised support to specific patients.

The areas where the provider should make improvements are:

- Continue with planned work to identify and support patients who are also carers.
- Continue with the planned review of hypnotic prescribing.

Overall summary

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

Background to West Gorton Medical Centre

West Gorton Medical Centre is located at 2 Clowes Street Manchester, M12 5JE. The surgery moved to this location in August 2017. The practice is part of the NHS Manchester Clinical Commissioning Group (CCG). The practice provides services under a General Medical Services contract with NHS England and has 6848 patients on its register. The practice website address is www.westgortonmedicalcentre.co.uk

The surgery is provided from a new purpose built medical centre, close to a busy main road and local to a residential area. The practice offers good car parking facilities, a local pharmacist and grocery shop are also available. The practice provides consultation and treatment rooms on the ground floor, with elevator access to the first floor for people with disabilities.

There are three female GP partners and two male salaried GPs, three practice nurses, one health care assistant, one assistant practice manager and a range of administrative and reception staff. The practice also employs a pharmacist as part of a pilot scheme. At the time of our inspection the practice manager had retired and a new practice business manager was due to commence work in June, as was a newly recruited advanced nurse practitioner.

The practice telephone lines are open Mondays to Fridays from 8am to 6.30pm. The practice facilities are open from 9am until 12.30pm Monday to Friday, except Tuesday when the doors open from 8.30am and in the afternoon from 2pm until 6.30pm. Extended hours are provided Monday, Tuesday and Thursday mornings from 7.30am until 8am for pre-booked telephone consultations and one late evening for appointments from 6.30pm until 8pm with a GP and a practice nurse. The practice can also offer patients a same day appointment at one of Primary Care Manchester's hub sites. These are local surgeries who offer extra appointments seven days a week for those patients who have an urgent need to see a doctor on the day. They also offer weekend appointments if preferred.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The male practice population have a lower life expectancy at 73.5 years compared to the CCG average of 74.8 years and England average of 79.2 years. Similarly, female life expectancy is lower at 78.2 years compared with the CCG average of 79.6 years and the England average of 83.2 years. The practice has a slightly higher number of patients under the age of 18 years, 26% compared with the CCG average of 24% and England average of 21%. Similarly, there is a higher number of patients over the age of 65 years (12%) compared with the CCG average (10%). The largest age group of patients registered at the practice are between 15 and 44 years.

The practice has 58% of its population with a long-standing health condition, which is higher than the CCG and the England average of 53% and 53.7% respectively.

The practice provides family planning, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

Good

Are services safe?

We rated the practice requires good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. Staff were also trained in recognising and responding to domestic abuse and clinical staff had received training in female genital mutilation.
- The practice implemented a policy 'Child not brought to appointment', to respond to children's lack of attendance at GP and hospital appointments; appropriate action was implemented. Productive working relationships with health visitors and school nurses were established.
- Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The last inspection in July 2016, undertaken at the GP practice's previous registered location identified that some checks in relation to recruitment were not in place. This inspection identified that appropriate checks were in place, including those for locum staff.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were comprehensive.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role. The GP locum pack provided comprehensive information.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

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

Track record on safety

Good

Are services safe?

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice, and the population groups, People with long-term conditions and Families, children and young people as outstanding for providing effective services, all the remaining population groups we rated good.

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice had their own Focused Care Worker who worked with patients and their families with different needs to support them to access primary care and secondary care appointments. These patients were reviewed regularly at a multidisciplinary team meeting.
- The practice was a pilot test site for the Citizens Advice Bureau (CAB). They provided a weekly advice surgery at the practice for all patients.

Older people:

This population group was rated good for effective because:

- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. The practice was in the process of undertaking frailty assessments of patients aged 65 years and over.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- As part of the practice's chronic disease management strategy a register of all patients living at home who were housebound was maintained. The practice implemented a planned programme of annual home visits to all these patients and this ensured that other health and social care issues were identified and responded to quickly.
- The practice undertook weekly GP visits to a 30 bedded care home that accommodated patients with complex needs. The regular patient monitoring also included pharmacist support including review of polypharmacy. We saw data that showed 71% of patients' preferred place of care and death was respected and that attendances at the local A&E department had been reduced 62%.
- The practice followed up on older patients discharged from hospital and ensured that patient care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

This population group was rated outstanding for effective because:

- The practice was proactive in undertaking opportunistic monitoring of its patient population which accounted for the high prevalence of patients with diabetes and chronic obstructive pulmonary disease (COPD).
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice had won two awards for the group work they were undertaking with diabetic patients. The purpose of this was to improve patient education and provide patients with tools to self manage their condition and to develop a patient support network independent of the practice. Initial results showed that the group consultations were effective in improving patients' control of their diabetes.
- The practice also offered a weekly COPD drop in programme for a group of patients that ran for six weeks. The hour long meeting included an exercise session, lifestyle and social prescribing support and access to the practice nurse and a GP if required.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

Are services effective?

Practice nurses took the lead on specific health conditions and worked closely with the clinical lead GP for that health condition. Two practice nurses were non medical prescribers for their clinical lead areas.
- GPs followed up patients who had received treatment in hospital or through Out of Hours services for an acute exacerbation of asthma. Weekly appointments slots were available for these patients.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention. Patients diagnosed with heart failure had a minimum of an annual review and evidence available showed patients were prescribed appropriately.
- Appropriate monitoring was undertaken for patients with suspected hypertension.
- Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice used the Quality and Outcomes Framework (QOF) which is a system intended to improve the quality of general practice and reward good practice.

Families, children and young people:

This population group was rated outstanding for effective because:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given between April 2016 and March 2017 were above the World Health Organisations target of 95%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had a policy in place 'Child not brought to appointment', whereby all non-attendance at primary care and secondary care appointments were coded on the child's patient record, searches undertaken to review the whole family dynamic and history of attendance at appointments and contact made with health professional and family or carer. We observed the implementation of this policy at the time of our visit.

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

This population group was rated good for effective because:

- The practice's uptake for cervical screening was 66.8%, which was higher that the local average of 64.9% but below the England average of 72.1%. The practice had undertaken some joint work with Cancer Research UK to review the practice performance and patient attendance for screening. At the time of our visit a medical student was being supported to implement a quality improvement project to improve this area.
- The practice had recognised that the high levels of local deprivation, high prevalence of obesity and an estimated higher prevalence of smoking lead to higher rates of cancer. The practice was therefore working with Cancer Research UK to try and improve patient participation in screening programmes including bowel cancer screening.
- The practice had participated in the Manchester Cancer Improvement Partnership (MCIP) which resulted in an increase in lung cancer diagnosis at an earlier stage.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated good for effective because:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Monthly palliative care meetings were undertaken with the palliative care team. Patients living in the care home supported by the GP practice had preferred place of care plans in place. GPs worked with patients to ensure these were respected.
- The practice held a register of patients living in vulnerable circumstances including asylum seekers and those with a learning disability. One GP had completed training two weeks previous to our inspection visit to become the practice champion for inclusion including the homeless, refugees and asylum seeker patients. Plans to develop this role were in place.

Are services effective?

- The practice referred patients with complex needs to the High Impact Primary Care (HIPC) service which supported people with a high level of health and care needs
- The patients with a learning disability received an annual health check and review. The practice provided recent examples of where patients were supported with their health check. For example one patient required regular blood test to monitor their condition. The patient refused the blood test. The GPs contacted the local hospital laboratory to obtain finger prick test kits to monitor the patient's health condition and working with the hospital consultant was able to maintain the patient on optimum treatment.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

This population group was good for effective because:

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long term medication. The practice provided examples whereby the Focused Care Worker supported patients to attend monitoring healthcare reviews at the practice.
- Patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their medical records and reviewed each year.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. For those diagnosed with dementia the practice offered an annual review at a face to face meeting every year. Patients and carers were also signposted to support services.
- Buzz Manchester supported patients and the Citizens Advice Bureau (CAB) also held weekly advice surgeries.
- The practice provided an in-house counselling service.

Monitoring care and treatment

The practice had a well-established comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- Where appropriate, clinicians took part in local and national improvement initiatives. These included participation in the Manchester Cancer Improvement Partnership (MCIP), piloting group consultation for diabetes and COPD, working with a Focused Care Worker, Buzz Manchester and the CAB.
- QOF results were similar to the clinical commissioning group (CCG) and national averages. Clinicians were clearly aware of the challenges of the local population demographics and worked hard to provide care and treatment to patients.
- The practice was aware that some of their rates of exception reporting were above the local and national average. They provided examples of where they were working to reduce the number of patients excepted from regular monitoring. These included quality improvement initiatives such as the annual visits for housebound patients, improving patient online access and improving uptake of cervical screening
- The practice used information about care and treatment to make improvements. For example the GPs held monthly educational and service development meetings with the staff at the nursing home the practice supported.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Outstanding ☆

Are services effective?

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings and appraisals. Systems of support to ensure the competence of staff employed in clinical roles including non-medical prescribing were in place.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- A comprehensive induction programme was in place for undergraduate medical students and trainee GPs. A structured training programme suitable to the stage of education and professional development of the medical students and trainee GPs supported this. One GP partner was the practice trainer and provided mentorship and clinical supervision.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The practice used working with a Focused Care Worker, Buzz Manchester and the CAB to provide additional support to patients.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for providing a caring service.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The results from the GP Patient Survey published in 2017 (recorded in the evidence table) showed the practice scoring similarly to or higher than the local and national counterparts.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. The practice referred patients to Buzz Manchester a health and wellbeing service and the Citizens Advice Bureau provided a weekly surgery at the practice.
- The practice proactively identified carers and supported them. The practice had recognised that their register of patients who were also carers was below the expected number given the size of the practice. The lead practice nurse was the carers' champion and had recently received some training to undertake this role. An action plan was in place to raise awareness in the patient population about the support available for carers.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice outstanding for providing responsive services and for population groups; older people, people with long term conditions and people whose circumstances make them vulnerable. Families, children and young people, Working age people (including those recently retired and students), and People experiencing poor mental health (including people with dementia) were rated as good.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. The practice worked with Buzz Manchester to provide social prescribing, the Citizens Advice Bureau to provide guidance and local charities such as Gorton Good Neighbours which provided a befriending service and local food banks.
- The practice had their own Focused Care Worker who worked with patients and their families with different needs to support them to access primary care and secondary care appointments.
- The practice used its television screening service also to signpost patients to local support services and raise awareness of health issues.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

This population group was rated outstanding for responsive because:

- The practice recognised the challenges their aging patient population faced in an area of high deprivation. They implemented a range of strategies to provide pro-active support and care to this population group. All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. A register of all patients living at home who were housebound was maintained. The practice implemented a planned programme of annual home visits to all these patients.
- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs
- The practice undertook weekly GP visits to a 30 bedded care home that accommodated patients with complex needs. The regularly patient monitoring also included pharmacist support. The practice worked with the care home staff to ensure patients preferred place of care and death were respected.
- The practice followed up on older patients discharged from hospital and ensured that patient care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice worked with Gorton Good Neighbours, a charitable organisation that provided a befriending service to help reduce social isolation and provide company on shopping trips.
- The practice team met with Age Friendly UK to seek advice regarding the design and layout of the practice premises and facilities.

People with long-term conditions:

This population group was rated outstanding for responsive because:

- Systems were in place to ensure all patients requiring a review of their long term condition received a comprehensive review and this included medication reviews.
- Longer appointments and home visits were available when needed. All housebound patients with a long term

Are services responsive to people's needs?

condition (including younger patients) were visited regularly to ensure the appropriate screening was undertaken. All these patients also had a self-management or an advanced care plan in place.
- Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. Opportunistic monitoring and screening was undertaken to help identify those patients at potential risk of developing a long term health condition.
- Patients identified as at potential risk of developing a long term health conditions were signposted and supported to attend learning events. For example patients with pre-diabetes were encouraged to attend a cooking course.
- The practice was implementing strategies to improve patients' awareness and self-management of their long term condition. These included patient group consultations for diabetes, whereby a group of patients attended a regular two hour meeting to discuss the illness, what blood results mean and how to self manage their illness. The added benefit for this type of health care review was the social aspects for the patient group to develop relationships with each other and to forge support networks outside of the formal GP group setting.
- The practice also offered six weekly one hour group drop in meetings with patients with COPD. This meeting also enabled patients to develop a social support network outside the group. The group meeting included an exercise session with a trainer, social prescribing and lifestyle support from Buzz Manchester and access to the lead GP and practice nurse for respiratory to provide health and medical support.
- Patients we spoke with said they valued these meeting. We observed examples of patients offering support to each other outside the GP practice.
- The practice held regular meetings with the multi-disciplinary team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

This population group was rated good for responsive because:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice implemented a same day access policy for all children and young people.
- The practice's Focused Care Worker supported families who struggled to attend GP and hospital appointments with their children.
- The practice, working with Shared Health had arranged for a Healthy Gems workshop to take place in June 2018. This two hour workshop was aimed at parents, guardians and children particularly the under five year olds. The purpose of the workshop was to develop relationships, provide information and advice on how to access support, provide information on what a healthy child is and how best to care for a poorly child.

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

This population group was rated good for responsive because:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were offered two evenings per week. The practice also offered patients a same day appointment at one of Primary Care Manchester's hub sites and this included weekend appointments.
- Telephone, consultations were also available
- Patients were able to book appointments and order repeat prescriptions online. One patient we spoke with found the online booking system for urgent appointments really useful and avoided waiting on the telephone.

People whose circumstances make them vulnerable:

This population group was rated outstanding for responsive because

- The practice had a comprehensive overview of those patients considered vulnerable and regular monitoring of these patients was undertaken. One GP had undertaken taken training to become the practice champion for inclusion including the homeless, refugees and asylum seeker patients.

Are services responsive to people's needs?

- Patients with complex needs were offered longer appointments. The practice provided examples of how they had supported individual vulnerable patients to ensure they received a person centred service.
- There were regular meetings with other health and social care professionals to discuss the care and treatment of vulnerable patients.
- Those patients with complex needs and frequent attendance at hospital emergency departments were referred to the High Impact Primary Care Team; where specific targeted health and social care support was implemented to help these patients better manage with their issues.
- The Focused Care Worker worked with patients to provide specific support to individual patients to ensure attendance at health care reviews. Monthly multidisciplinary team meetings reviewed the patients supported by the Focused Care Worker. The practice provided examples of patients who had been successfully supported by this service.
- The practice had established strong links with Buzz Manchester, a health and wellbeing social prescribing service that visited the practice regularly and supported patients with signposting to support services.
- Citizens advice bureau (CAB) also held weekly advice surgeries for patients at the practice.
- The practice had a comprehensive palliative and end of life strategy in place and this was supported with clinical protocols. The practice held monthly multidisciplinary team meetings where vulnerable or at risk, patients were identified including those newly diagnosed with cancer.
- Drug and alcohol support services were available at the practice.

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

This population group was rated good for responsive because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice offered in-house counselling to patients assessed with low level mental health concerns.
- The practice proactively signposted patients to support organisations for those with mental health needs.
- The practice offered social prescribing and citizens advice services and had forged links with local charities including Gorton Good Neighbours and food banks.
- The practice Focused Care Worker supported patients to attend primary care and secondary appointments. The practice provided examples of patients who frequently did not attend doctor and hospital appointments who now attended these with the additional support of the Focused Care Worker.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The results of the GP Patient Survey published in July 2017 for the practice reflected similar levels of patient satisfaction with access to appointments when compared with local and national averages. One area identified with lower satisfaction score was in relation to telephone access. Since this survey the practice had moved to another location with modern and improved telecommunication access.
- The practice had implemented the NHS package Productive General Practice (PGP) Quick Start programme which aims to help release time for the practice team for care and to build improvement capability. One of the areas identified by the practice was the appropriate use of appointments by patients. Analysis of the data identified that many of the GP appointments patients attended could have been provided by an advanced nurse practitioner (ANP). As a result the practice had recruited an ANP who was scheduled to commence employment in June 2018.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

Outstanding ☆

Are services responsive to people's needs?

- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. All patient complaints were discussed with staff so that they could reflect on their practice. In all cases, patients were reassured that their treatment had been appropriate and further advice had been given.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice outstanding for providing well-led services because:

Leadership capacity and capability

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

- The GP Partners were a driving force, united in their commitment to deliver person centred care to their patient population. They effectively used the skills and abilities of their staff team and the resources available in the local community to provide innovative and accessible care, treatment and support to their patients.
- The practice leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges affecting their patient population and the local area population and were passionate in involving patients in the management of their own health and wellbeing.
- The practice leaders attended meetings to contribute to wider service developments and frequently participated in a range of pilots to bring services closer to the practice patient population.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The practice's mission statement, 'Quality Service, Quality Life' was underpinned by its vision and values and strategic objectives. The practice values were driven by the GP partners and understood and embraced by all practice staff we spoke with.
- The practice's underpinning ethos was that the patient was central to all its activities. It involved patients in learning and understanding about their health conditions to promote improved self-management and it utilised effectively community resources to ensure their patients received as much support as possible.
- The practice team of staff all demonstrated the GP partners shared ethos of providing the best care for their patient.

Culture

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

- The practice fostered a culture of partnership and collaboration between all stakeholders including patients, staffing, external professionals and local charitable initiatives.
- All staff were considered valuable members of the team and those we spoke with were clear on their contribution to providing the best service to patients and the rest of the team. Staff had the autonomy to undertake quality improvement work for the benefit of their patients. For example one practice nurse was leading on developing and improving their service to patients who were also carers.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. The monthly practice team meeting contained the standing agenda item 'In the Loop' which provided staff the opportunity to voluntary share any personal issues (should they wish to) with the staff team.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Further training, Pride in Manchester was scheduled for July 2018 for all the staff.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were well established, clearly set out, understood and effective.
- Governance arrangements were proactively reviewed and reflected best practice

Outstanding ☆

Are services well-led?

- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice implemented a range of quality improvement initiatives to improve patient outcomes; examples included the drop in group meetings for chronic obstructive pulmonary disease, improving patients' online access and improving patient attendance for cytology screening.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient reference group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice, this included development of protocols following serious events, improving administrative systems after complaints and responding to data in relation to performance.
- The practice had implemented the NHS package Productive General Practice (PGP) Quick Start programme. This review and subsequent implementation of two key areas improved areas of service delivery including the appropriate use of appointments with the recruitment of an advanced nurse practitioner and improved document workflow management.
- The practice was a long-standing teaching and training practice. The practice supported medical students and

trainee GPs with their education. The practice used this resource effectively to develop skills and abilities by delegating responsibility to undertake planned and co-ordinated quality improvement projects.

- The practice was proactive in participating in pilot schemes for the benefit of their patients. For example offering group diabetic consultation, a weekly group COPD drop in, a weekly citizens advice presence, the use of a Focused Care Worker, Buzz Manchester a health and well-being service and an onsite pharmacist.
- The practice had won two awards recently for their work with diabetic group consultations.
- An action plan for development of areas including patient participation, care navigation training for staff and improving social media links was in place.

Please refer to the Evidence Tables for further information.