Bodmin Road Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Bodmin Road Health Centre.

We carried out a comprehensive inspection on 14 January 2015. We spoke with patients, a member of the Patient Participation Group (PPG) and staff, including the management team.

The practice was rated as good overall.

Our key findings were as follows:

- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. When things went wrong reviews and investigations were carried out.
- National Institute for Health and Care Excellence (NICE) guidance was used routinely. Patients' needs were assessed and care planned considering current guidance.
- We found high levels of patient and staff satisfaction. Patients were extremely happy with the service provided by the practice. They told us they were treated with compassion, dignity and respect. The staff team was stable and staff told us they felt supported and valued in their roles.
- Patients confirmed they were able to contact the practice and speak with a health practitioner in a timely and accessible manner. Patients told us they could always get an appointment when they needed one, including on the same day if it was urgent. Recent issues with regards to the telephone system were raised by some patients. It was clear the practice had begun to take steps to assess and resolve this issue.
- The practice took time to listen to the views of their patients and ran an active Patient Participation Group. Actions were identified and taken to improve the service.

Summary of findings

- Staff of all levels were allocated a 'buddy'. This ensured that if staff who had key responsibilities were off sick or unavailable another member of staff could conduct their duties in an effective way

We saw several areas of outstanding practice including:

- Bereaved families were visited at home to offer emotional support and to sign post to other services. Staff who knew the family well also offered to attend funerals to offer their support.
- The practice held a carers service clinic each week. Patients were referred to this service, or could refer themselves. This service provided onsite support, both emotional and practical in nature, to patients acting as carers.
- The practice actively promoted a social enterprise commissioned by Trafford Council. This service provided information and a support network to patients who may experience emotional or psychological distress in order to improve their mental wellbeing. Leaflets were available and a dedicated computer which patients could access to gain further information about the service.

There were also areas of practice where the provider needs to make improvements.

The provider should:

- Regularly review policies, including infection control, to ensure these are relevant to the service, up to date and available to staff.
- Include Mental Capacity Act (2005) and DoLS (Deprivation of liberty safeguards) in staff training.
- Review monitoring processes to ensure timely recurrence of risk assessment and staff training.
- Ensure suitable arrangements are in place to demonstrate the safety of the storage and use of liquid nitrogen to protect service users and others who may be at risk.
- Review repeat prescribing processes to ensure patients who require more frequent review are safely monitored.

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 their responsibilities to raise concerns and reported incidents appropriately. Investigations were completed and measures were identified to reduce the risk of incidents reoccurring.

Staff were knowledgeable about what constituted a safeguarding concern. A GP took the position of safeguarding lead for the practice and staff knew who to contact. Recruitment checks were conducted for clinical and non-clinical staff.

The practice had appropriate stocks of equipment and drugs for use in the event of an emergency. However the practice failed to demonstrate how such as liquid nitrogen was risk assessed and managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

Care and treatment was delivered in line with current published best practice. Staff meetings and audits were used to assess how well the service was delivered.

Consent to treatment was always obtained where required and this was confirmed when speaking with patients.

The practice regularly met with other health professionals and commissioners in the local area in order to review areas for improvement and share good practice.

Are services caring?

Good

Are services caring?

The practice is rated as good for providing caring services.

Patient feedback was consistently highly positive in this area. This was across CQC comment cards, patient surveys and speaking to patients on the day of our inspection. Patients told us staff were caring, friendly and approachable and they were treated with respect, dignity and compassion.

Staff we spoke with were aware of the importance of providing patients with privacy during appointments and when visiting the reception desk. Patients were encouraged to stand back from the desk, security screens were used on reception computers and a private room was offered to facilitate private discussions.

Summary of findings

The practice was proactive in supporting patients to ensure they received the care they required. The results of the 2014 National GP Survey show that 98% of patients said their GP was good or very good at treating them with care and concern and giving them enough time. 95% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. These figures were consistently higher than the CCG average of 87%, 88% and 83% respectively.

We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Bereaved families were visited at home to offer emotional support and to sign post to other services. Staff who knew the family well also offered to attend funerals to offer their support.

The practice held a carers service clinic each week. Patients were referred to this service, or could refer themselves. This service provided onsite support, both emotional and practical in nature, to patients acting as carers.

The practice actively promoted a social enterprise commissioned by Trafford Council. This service provided information and a support network to patients who may experience emotional or psychological distress in order to improve their mental wellbeing. Leaflets were available and a dedicated computer was available which patients could access to gain further information about the service.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG) to secure service improvements where possible.

Patients reported good access to the practice. Appointments were available on the same day they were requested. The practice was aware of recent feedback from patients regards the telephone systems and had begun to take steps to address this.

The practice sought to gain patient feedback and had an active Patient Participation Group (PPG) who provided ideas and suggestions to help improve the service.

We saw evidence that complaints were responded to quickly and that staff were involved in discussions around ways to improve.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services.

All staff we spoke with felt valued and told us they were individually supported to progress in their roles.

The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstrated in their behaviours.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions.

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

Good

The practice is rated as good for the care of older people.

The practice was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner. The practice was responsive to the needs of older people including offering home visits as required and there was a practice plan to reduce avoidable A&E attendance in all groups which included older people.

The practice had a register of all patients in need of palliative care or support irrespective of age. District Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions.

There was a high prevalence (59%) of patients with long standing conditions, such as cardiovascular disease and diabetes. Patients had as a minimum an annual review of their condition and their medication needs were checked at this time. When needed, longer appointments and home visits were available.

Patients at risk of being admitted to hospital due to their condition had a care plan in place, this was regularly reviewed.

Information was available on the practice website, leaflets and the practice 'life'' channel were also available to assist patients to manager their conditions. A wide range of health promotion literature was available.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Children and young people were treated in an age appropriate way and their consent to treatment using appropriate methods was requested.

There was access to on the day appointments where parents had concerns about the health of their child.

Summary of findings

There were comprehensive screening and vaccination programmes which were managed effectively to support patients. Community midwives attended the surgery every Wednesday.

The practice monitored any non-attendance of babies and children at vaccination clinics. The practice maintained a register to identify children at risk.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people and those recently retired.

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and telephone consultations.

The practice kept their opening hours under review in order to meet the needs of the patient population registered at the practice.

Extended opening hours were available on Tuesday evenings to meet the needs of the working age population.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. Patients with learning disabilities were offered annual health checks and longer appointments were available if required.

Staff knew how to recognise the signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health.

The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

GPs worked with other services to review and share care with specialist teams. The practice maintained an electronic system of patients who experienced mental health problems.

Summary of findings

Staff sign-posted patients experiencing poor mental health to various support groups. Staff at the practice knew how to refer people to a social enterprise commissioned by Trafford Council. This service provided a support and information service for adults to assist people with a wide range of issues affecting their mental health.

Summary of findings

What people who use the service say

We received 40 completed CQC comment cards and spoke with five patients visiting the surgery on the day of the inspection. We received feedback from male and female patients across a broad age range.

The feedback we received was consistently very positive. Comments from patients included that the service and care they received was excellent.

Patients we spoke with on the day told us that all staff at the practice were friendly, caring and approachable. Patients consistently told us they were extremely happy with the care they received at the practice and they would recommend it to their family and friends.

We also reviewed recent feedback left by patients on the internet and in patient surveys. Again this was consistently very positive.

The results of the 2014 National GP patient survey showed that 91% of respondents from this practice described the overall experience of their GP surgery as good. 98% of patients said their GP was good or very good at treating them with care and concern and 95% said their GP was good or very good at involving them in decisions about their care. These figures were all above the national average. Figures relating to the care from nursing staff were slightly below the national average.

Areas for improvement

Action the service SHOULD take to improve

- Regularly review policies to ensure these are relevant to the service, up to date and available to staff.
- Include Mental Capacity Act (2005) and DOLS (Deprivation of liberty safeguards) in staff training.
- Review monitoring processes to ensure timely recurrence of risk assessment and staff training.
- Ensure suitable arrangements and risk assessments are in place to demonstrate the safe storage and management of liquid nitrogen
- Review repeat prescribing processes to ensure patients who require more frequent review are safely monitored

Outstanding practice

- Bereaved families were visited at home to offer emotional support and to sign post to other services. Staff who knew the family well also offered to attend funerals to offer their support.
- The practice held a carers service clinic each week. Patients were referred to this service, or could refer themselves. This service provided onsite support, both emotional and practical in nature, to patients acting as carers.
- The practice actively promoted a social enterprise commissioned by Trafford Council. This service provided information and a support network to patients who may experience emotional or psychological distress in order to improve their mental wellbeing. Leaflets were available and a dedicated computer which patients could access to gain further information about the service.

Bodmin Road Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP and a practice nurse specialist advisor.

Background to Bodmin Road Health Centre

Bodmin Road Health Centre provides a service to 7050 patients and is part of the Trafford Clinical Commissioning Group (CCG).

The largest percentage practice population are patients aged under 18 years, accounting for 20.3% of practice patients. 59.2% of patients have a long-standing health condition, compared to the national average of 53.4%.

According to statistics available at the time of the inspection from Public Health England, the practice is in the seventh least deprived percentile for practices in England, on a scale of one to ten.

The practice is open Monday to Friday between the hours of 8am and 6pm. The practice also operates extended opening hours which are available on Tuesdays until 8.30pm.

When the practice is closed and in the Out of Hours (OOH) periods patients are requested to contact 999 for emergencies or telephone 111 for the OOH service provided by Mastercall. This information is available on the practice answerphone and practice website.

The practice has five GPs (two male and three female), and two female practice nurses. The practice also has a practice manager and staff are all supported by administration, reception and secretarial staff.

The practice is a training practice and regularly has medical students

Why we carried out this inspection

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

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

Detailed findings

- 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 we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew. We spoke with a member of the Patient Participation Group (PPG). The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 14 January 2015. During our visit we spoke with GPs, members of the nursing team, the practice manager, reception and administration staff. We observed how staff communicated with patients. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service and spoke to five patients visiting the practice on the day.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included complaints, findings from clinical audits, significant events and feedback from patients. Staff were clear about their responsibilities in reporting any safety incidents.

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The quality and outcomes framework (QOF), which is a national performance measurement tool, showed that the provider was appropriately identifying and reporting incidents.

There were mechanisms in place for the prompt management of safety alerts. The practice manager shared these by email with the relevant staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events which all staff members were aware of. The practice had an open, honest and transparent culture and staff were encouraged and supported to report any incidents. Monthly staff meetings were used to discuss and communicate learning and improvements from complaints and incidents. It was clear that the staff we spoke to were knowledgeable about such events and the actions taken to prevent reoccurrence.

The significant event log we reviewed showed that that learning was identified and improvements were made and sustained. We could see that staff and patients were involved in these improvements. The practice manager told us that they were looking at analysing the trends of such incidents for the previous year which would further strengthen this process.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GPs and the practice manager and action was taken as required.

Staff told us that any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed in clinical staff meetings. This information sharing meant the GPs and nurses were confident the treatment approaches adopted followed best practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff at the practice, including the receptionists, were proactive when following up information received about their patients, specifically those who were vulnerable to risk of harm.

Staff we spoke with had a good awareness of how to recognise signs of abuse in vulnerable adults and children. All staff had completed adult safeguarding and child safeguarding to a level appropriate to their role, with the lead GP being trained to level three.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies both in and out of hours.

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew these were available on the practice intranet. There was also access to local authority contact names and numbers.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities.

Staff we spoke with understood what was meant by the term Whistleblowing and a policy was in place to assist staff to expose poor care or bad practice.

Details about chaperone facilities were seen in the waiting area and treatment rooms. We were told that this service was provided by clinical staff only.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and appropriately and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. Checks were conducted to ensure temperatures were within the

appropriate limits and that stock was appropriately ordered and in date. Expired and unwanted medicines were disposed of in line with waste regulations. These processes were supported by the CCG medicines policy.

The practice processed repeat prescriptions within 48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way, and were often ready for collection the next day. The practice checked that patients receiving repeat prescriptions had an annual medicine review with the GP. This process was supported by the repeat prescribing policy.

Cleanliness and infection control

We observed the premises to be clean and tidy. Arrangements were in place with an external contractor for the cleaning of the practice. Comprehensive schedules were in place and cleaning records were kept. Patients told us they were happy with the cleanliness of the practice.

An infection control policy was available for staff however it was clear that this was not referred to. This policy stated that internal audits would be completed on a bi-monthly basis, but this was not the case. On the day of our inspection staff could not access supporting procedures such as needlestick injury and hand washing protocols. The practice manager told us policies would be revisited to ensure they were fit for purpose, adhered to and available to all staff.

We saw evidence that the practice had requested support from the local NHS Trust to carry out an infection prevention and control (IPC) audit of the practice in the last six months and an action plan with improvements identified had been completed.

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

The practice had systems in place for the segregation of clinical and non-clinical waste. An external contractor attended the practice on a weekly basis to collect clinical waste and remove it off site for safe disposal.

Legionella testing was conducted on a monthly basis however the yearly risk assessment for the building which included legionella had lapsed, expiring in June 2014.

All staff received induction training about infection control and updates thereafter. Staff told us that they were required to provide evidence of their immunisation against Hepatitis B. However we did not see evidence that this was recorded.

Equipment

There was a contract in place to check that medical equipment was calibrated to ensure it was in working order. The practice also had contracts in place for portable appliance checks to be completed on an annual basis.

The practice had a defibrillator which ensured they could respond appropriately to a patient experiencing a cardiac arrest. Staff told us they had been trained to use this equipment.

Emergency equipment including oxygen was readily available for use in the event of an emergency. We saw evidence that this was checked after it had been used and on a regular basis.

The practice stored liquid nitrogen on site which was used to provide a cryotherapy clinic. Cryotherapy is the use of liquid nitrogen at low temperatures to treat lesions such as warts and verruca's. We asked the practice how they assured themselves that the storage, decanting and use of this liquid was safe. The practice manager told us they had taken guidance from the fire service with regards to the storage and as such this was stored in a separate, locked room. However, there was no recent risk assessment or other paperwork available. We were told the registered manager had access to the liquid nitrogen and was suitably trained however evidence of this was not available.

We were also told that other health professionals visited the practice to decant liquid nitrogen for use in their own practice. We asked to see evidence that this had been risk assessed and if a service level agreement was in place, but this had not been completed. The practice manager assured us these matters would be discussed with the health and safety representative urgently and before it was used again.

Staffing and recruitment

The practice recruitment identified which checks were required prior to the employment of a member of staff. We saw evidence that appropriate pre-employment checks were completed for a recent successful applicant before they could start work in the service.

Good

Are services safe?

All the GPs had disclosure and barring service (DBS) checks undertaken annually by NHS England as part of their appraisal and revalidation process. The nurses also had DBS checks undertaken and copies of this were kept.

There was an established and stable team at the practice, with many staff being employed there for a number of years.

We also saw evidence of forward planning. The practice had identified future concerns relating to staffing, such as retirement of staff, and had plans in place to recruit accordingly.

Monitoring safety and responding to risk

The practice team had agreed the requirements for safe staffing levels at the practice. Staff worked regular sessions and set days each week to maintain the service provided.

Reception and administrative staff, in the event of staff sickness or leave, supported each other to provide cover amongst the remainder of the staff. The staff were multi skilled and operated a 'buddy' system which enabled them to cover for each other in the event of planned and unplanned absence.

The practice manager routinely checked the professional registration status of GPs and practice nurses with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice. The practice manager assured us that these checks would be recorded.

The practice demonstrated that advanced planning had been considered and implemented for recent changes. This included introducing a new timetable and the employment of extra staff.

Extended hours were available on Tuesday evenings and emergency appointments slots were kept free each day.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan in place. This plan gave staff guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included fire, flood, and loss of electricity supply and telephone system. The document also contained relevant contact details for staff to refer to.

Records showed that staff had completed fire training and staff told us they practised regular fire drills.

Emergency equipment was readily available and included a defibrillator and oxygen. Checks were undertaken to ensure they were ready for use and in date.

Each room had access to a panic alarm which could be used to raise an alert to all other members of staff if assistance was required. Staff we spoke to were aware of this system and gave examples of how it had been used effectively in practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate. New patient health checks were offered and regular health checks and screenings were on-going in line with national guidance.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system. A peer review system was also in place which meant a second GP reviewed all secondary care referrals to ensure these were suitable and appropriate.

Patients we spoke with said they were happy with the care and treatment they received at the practice. They told us they were involved in decisions about their care and that staff explained options and involved them in the process.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included an audit of monitoring of urate levels in patients receiving long term treatment for gout in response to NICE guidance and an audit regarding HRT (Hormone Replacement Therapy) monitoring. We saw evidence that these audit cycles were completed in full and that these were reviewed to ensure actions taken were having the desired impact to improve outcomes for patients.

Patients we spoke with who had long term health complaints confirmed they received regular health reviews and were called by the practice to arrange these. We saw evidence of these systems in the practice.

Care plans were in place for patients with complex or multiple health conditions. This enabled the practice to effectively monitor patients at regular intervals.

Electronic systems had alerts when patients were due for reviews and ensured they received them in a timely manner, for example, management of chronic conditions. The practice had systems in place to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic. We found that vaccination rates were above the average for the CCG as was the uptake rates for cervical smears. The practice also provided out of hours Flu Clinics on Saturday mornings which were supported by all levels of the staff team.

Two of the GP partners undertook minor surgical procedures (joint injections) within the practice in line with their registration and NICE guidance. A cryotherapy clinic was held at the practice and a weekly phlebotomy clinic. This was available to patients from other practices which gave easier access to more local services rather than having to travel to the local hospital.

Regular clinical meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with palliative care staff which resulted in a positive outcome for the patients concerned. The practice reported that communication channels had become difficult with community services due to lack of continuity and they hoped this would improve in the future.

The practice used the information they collected for the Quality Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF data was subject to on-going monitoring to ensure the needs of patients were identified and met in a timely manner. For example, to ensure that those with long term conditions, learning disabilities or mental health issues attended for regular review.

Effective staffing

The practice team included medical, nursing, managerial and reception staff. We reviewed a sample of staff training records and saw staff were up to date with attending mandatory courses such as basic life support, however the systems to record and monitor staff training required strengthening.

Each member of staff was expected to have an annual appraisal. Records confirmed that this was the case.

We saw evidence of on-going monitoring of performance; GPs reviewed each other's work and educational meetings

Good

Are services effective?

(for example, treatment is effective)

were held within the practice. Four hours protected learning time was allocated each month for clinical staff to undertake educational meetings. This also included time to identify and discuss significant events

The GPs covered each other for annual leave and sickness. Staff worked in a flexible manner and assessed and changed the appointments available on a regular basis to ensure they were meeting the needs of the patients.

The GPs were up to date with their yearly continuing professional development in line with the requirements of the General Medical Council.

Working with colleagues and other services

The practice worked with other agencies to support continuity of care for patients. Information received from other agencies, such as accident and emergency and OOH service, was read and actioned by the GP and scanned onto patient records in a timely manner.

The practice worked with the local community nursing team, midwives and health visitors. Clinicians appropriately referred patients to community teams. For example pregnant women were seen by the community midwives for their ante-natal appointments.

Information sharing

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets were available within the practice waiting room.

The practice had systems to provide staff with the information they needed. Staff used a recently installed electronic patient record system to coordinate, document and manage patients' care. All staff were trained on the system and commented positively about the system's safety and ease of use; however further training had been arranged to allow the system to be used to its full potential. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider that enabled patient data to be shared in a secure and timely manner.

Electronic systems were also in place for making referrals to secondary care (hospitals). The 'Choose and Book' system enabled patients to choose which hospital they will be seen in and book their own outpatient appointments in discussion with their chosen hospital.

In appropriate situations patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend practice meetings. Information sharing also took place within multi-disciplinary team meetings, for example in palliative care meetings.

Consent to care and treatment

The practice had a comprehensive policy on consent and decision making for patients who attended the practice. The policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

Templates had been produced for completion in circumstances where written consent from the patient was required, for example, immunisations. We were told that where patients gave verbal consent to care and treatment it was recorded in their notes.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation. However some staff felt they required further training around Deprivation of Liberty Safeguards (DoLS). The practice programme of e-learning available to staff included modules on Mental Capacity Act 2005 and DoLS but this had not been accessed.

Health promotion and prevention

The practice supported patients to manage their health and wellbeing. Vaccination programs, long term health reviews and health promotion information were provided to patients.

Good

Are services effective?

(for example, treatment is effective)

Patients were assisted to access support services to help them make lifestyle improvements and manage their care and treatment.

All new patients were asked to complete a health questionnaire and offered a consultation. We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

We saw that there was a wide range of health promotion information on display in the waiting areas and leaflets explaining different conditions were also freely available in the treatment rooms of the practice. Local voluntary services and services available within the practice were advertised on both the notice boards and TV screen. A dedicated wellbeing board called 'in your area' provided information about a variety of local support groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the results of the 2014 National GP Survey. This showed that 98% of patients seeing a GP and 90% of patients seeing a nurse said the GP or nurse was good or very good at treating them with care and concern. We spoke with five patients whilst in the practice and received 40 completed CQC comment cards. Comments we received were all extremely positive about all aspects of the service.

Patients told us they are treated respectfully by staff and many commented that staff were friendly and approachable. Patients said their privacy and dignity was maintained and that the care they received was excellent.

All patient appointments were conducted in the privacy of a consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. Staff and patients informed us they were aware there was a room available if patients or family members requested a private discussion. We found that patient confidentiality was respected in the waiting area. Signs encouraged patients to stand back from the desk until they could be seen. The computers behind this desk had been fitted with security screens to ensure patients could not see confidential information.

The patient electronic system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, where a patient had a learning disability.

We were told by a member of the Patient Participation Group (PPG) that the practice listened to their comments and they felt they could influence changes in the practice in the future. We saw evidence that suggestions had been listened to and actioned.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that patients felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed in their appointment. Comments from patients included that they felt listened to and treated with respect, and options were always discussed.

Care plans were in place for patients receiving palliative care and the GP supported patients with discussion about end of life preferences as appropriate. These care plans were kept up to date and shared with relevant healthcare professionals.

A coding system on the computer system in the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities.

All the staff we spoke with were effective in communication and all knew how to access an interpreter if required.

The 2014 GP patient survey reported that 95% of respondents said the last GP the practice was good at involving them in decisions about their care and 98% said their GP was good or very good and treating them with care and concern. 99% and 98 % respectively of respondents said they had confidence and trust in the last GP or nurse they spoke to. These figures well above the CCG average.

Patient/carer support to cope emotionally with care and treatment

The practice had systems in place that reflected best practice for patients nearing the end of their life and demonstrated an ethos of caring and striving to achieve a dignified death for patients. We were told that in appropriate cases GPs had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patient's wishes were managed in a sensitive and appropriate way.

Multi-disciplinary supportive care meetings were held to discuss the needs of those approaching end of life.

It was clear that staff knew patients well. In times of bereavement staff attended funeral services to provide support to family members if required. GP's also contacted family members to offer follow up visits at these sad times.

The practice had a display of information including how patients could access emotional support, including counselling. The practice held records of carers and the carer's service visited the practice each week which patients could also self-refer to. This service provided support both emotional and practical, for example benefits access and sign posting to other groups and services.

Good

Are services caring?

Patients had access to a “Blu Sci” computer and information leaflets (a social enterprise commissioned by Trafford Council). This service provided information and a support network to patients who may experience emotional or psychological distress in order to improve their mental wellbeing. This was promoted throughout the practice and sign posted to by staff where appropriate.

A life channel played in the waiting area giving patients information about the practice and health promotion information.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice liaised regularly with the NHS Local Area Team and Clinical Commissioning Group (CCG) to discuss local needs and identify service improvement plans. This included improving access to the service for patients for appointments. The practice had recently negotiated funding in order to conduct an in depth analysis of the appointment system. The practice had identified that due to a recent increase in patient numbers this was becoming an issue.

Patients we spoke with and the CQC comment cards we received confirmed patients were generally happy with the practice appointment system. Patients told us they could get an appointment the same day if they needed to.

On- line booking had also been introduced and we saw this was being promoted around the practice. A revised the appointment system and more on the day appointments and daily telephone appointments had recently been introduced.

The practice had also implemented a Patient Participation Group (PPG). We spoke to one member of the PPG who told us the practice gained feedback from patients via a virtual group as this assured the most representative views of the practice population could be obtained. Regular patient surveys were used to identify areas for improvement. We saw evidence of action taken as result and review of this.

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

It was clear that staff knew the patients well. We were told that longer appointments would be offered if, for example, a patient was anxious or had a learning disability.

Comments we received from patients included that they were treated as a person, staff were diligent, considerate and committed and that all the staff had a caring attitude. One person said this practice was a shining example of how good the NHS can be and another simply stated the practice was everything that was good about the NHS.

Tackling inequity and promoting equality

The new patient list at the practice was open and staff were able to offer appointments to patients including to those with no fixed abode. The practice also provided a visiting service to care for assessment patients in a temporary local authority care home.

The computer systems at the practice enabled staff to place an alert on the records of patients who had particular difficulties so staff could make adjustments. For example, if a patient had carer support or learning difficulties. Staff told us they would offer longer appointments to patients when needed. The practice has recently changed their computer system to reflect need for integration with other services.

Public Health England data found the practice's average male life expectancy was 78.6 and female life expectancy 83.4 years, compared to England's national average of 78.9 for males and 82.9 for females. Clinical staff held a number of regular clinics at the practice to provide health promotion information and advice on matters such as chronic disease management, immunisation and vaccination and diabetes.

Staff were knowledgeable about language issues in the local community and interpreter services were available if required.

Access to the service

The practice was purpose built on the ground floor and was visibly clean and well maintained. There were two car parks with dedicated disabled bays closest to the entrance door. There were adequately spacious waiting areas and corridors and doorways were wide enough to accommodate wheelchairs. Disabled toilet and baby changing facilities were available.

The practice was open Monday to Friday from 8am until 6pm, with extended hours available until 8.30pm on Tuesdays. The practice offered emergency on the day appointments every day with pre bookable appointments also available. Home visits were available every day. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and on the website. GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be arranged.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Responses to the national and practice patient survey showed that patients were overall very satisfied with the practice. This was consistent with the responses we received on CQC comment cards. Overall 91% said they would recommend the practice.

When the practice was closed the care and treatment needs of patients were met by the out of hour's provider Mastercall. Contact information for this service was well publicised by the practice.

Some CQC comment cards we received and patients we spoke to told us that in recent weeks they had noticed it had become harder to obtain appointments and that telephone lines were extremely busy at 8am. The 2014 GP Patient Survey also reflected this concern as figures relating to satisfaction in this area had decreased from last year. It was clear that the practice were aware of this issue and were taking steps to address it.

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. Two complaints had been made by patients or their family and we saw these were dealt with in a timely manner. Investigations addressed the original issues raised and action was taken to rectify the problem. Staff told us these were discussed at practice meetings and where changes could be made to improve the service these were put in place.

All the staff we spoke with were aware of the system in place to deal with complaints. They told us feedback was welcomed by the practice and seen as a way to improve the service.

The practice manager regularly reviewed the NHS Choices website for patient comments. On the day of our inspection all the feedback received was extremely positive. Staff confirmed that this was fed back to them in meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy.

We saw evidence that GPs met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. Access to appointments and an increase in patient numbers had recently been discussed and plans were in place to allow a thorough review of the system.

The staff we spoke with were clear on their role and responsibilities within the practice. There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff. We found that policies, for example infection control did not reflect the current structure. The practice manager assured us that polices would be revisited and reviewed to address this.

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. We found there was a clear vision throughout the practice to offer high quality care. We observed this in practice on the day of our inspection and patients confirmed this was consistently the case.

There was a clear team working ethos that demonstrated all staff worked to a common goal and had contributed. Most staff had been working at the practice for a number of years and had been part of the development of the service. All staff were clear on their roles and responsibilities and each strived to offer a service that was friendly and accessible to all patients.

Staff told us they felt valued and that their views about how to develop the service were acted upon. There was evidence that staff were offered incentives for good work and patient care, and there was an obvious bond between staff of all levels.

Governance arrangements

We saw systems in place for monitoring service provision such as complaints, incidents, safeguarding, and clinical audit. However, staff training, policy review and risk assessments required review to ensure these were up to date and appropriate.

The practice manager was responsible for ensuring policies and procedures were kept up to date. These systems could be strengthened to ensure they were monitored in an efficient way to ensure documents were wholly relevant to the practice.

All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. Those systems and feedback from staff showed us that strong governance structures were in place.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for the practice showed it was performing in line with national standards with an average score of over 97% for 2013.

Leadership, openness and transparency

We saw there was a clear leadership structure in place. Staff told us they felt valued, well supported and knew who to approach in the practice if they had any concerns.

Staff told us they had the opportunity to ask questions during staff meetings or to approach the practice manager at any time. Administrative staff told us they were also encouraged to have meetings where management were not present but where minutes were taken. This was to encourage staff to feel comfortable to share issues and suggestions.

The practice manager and GPs undertook appraisals for all members of staff on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake.

The GPs received appraisal through the revalidation process. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active virtual Patient Participation Group. We spoke to a member of the group who

Are services well-led?

Good

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

commended the practice for their ability to listen to suggestions to improve the service. The member told us action had been taken to improve the service or that where this was not possible that full explanations were given.

Staff told us patient feedback was discussed at practice meetings to see if there were any common themes where improvements could be made. Some staff were also involved in the PPG meetings held at the practice.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns, which showed there were processes in place to assist staff to expose poor care or bad practice. Staff we spoke to were also aware they could also contact CQC and were able to demonstrate practical experience of effective whistleblowing.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure staff had access to learning and improvement opportunities.

Newly employed staff had a period of induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. However, there was no clear system to monitor staff training.

GPs were supported to obtain the evidence and information required for their professional revalidation. Nurses were also registered with the Nursing and Midwifery Council (NMC), and as part of this annual registration were required to update and maintain clinical skills and knowledge. The nursing team met regularly for clinical supervision however this was not recorded. Their appraisal was carried out by a practice GP.

The GPs discussed the challenges for services however the practice aimed to be innovative and participate in future local developments, working closely with other practices and the CCG.

The practice completed reviews of significant events and other incidents and shared results and findings with staff at meetings to ensure the practice learned from and took action, which improved outcomes for patients.