

# Denton Medical Practice

## 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Denton Medical Practice on 15 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all the population groups that we assess.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they usually found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.

The areas where the provider should make improvements are:

- Improve infection control protocols and policies to support good infection control practices.
- Improve security and accountability of handwritten prescription pads

**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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received most training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked effectively with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Health care assistants provided high levels of care to people not able to routinely attend for consultations at the practice.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they usually found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Good



# Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders.

## Are services well-led?

The practice is rated as good for being well-led. Management had a clear vision and strategy; not all staff were clear on this. Staff were clear about their responsibilities in relation to ensuring high standards of patient care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, some of which required reviewing. The practice held regular governance meetings to ensure continuous improvement. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a patient participation group (PPG) and the practice planned to share information from their meetings more widely. Staff had received inductions, regular performance reviews and attended staff meetings and events.

**Good**



# 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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice successfully gained additional finance to undertake multi-agency work to improve the quality of care for older people.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Self-empowerment was promoted so that patients could be more involved in their own health management and improvement.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours, with a practice based midwife service being available. We saw good examples of joint working with health visitors and outreach clinics.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Good



# Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

## People whose circumstances may make them vulnerable

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 including homeless people, asylum seekers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise 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 normal working hours and out of hours.

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and patients are referred to a memory assessment clinic when appropriate.

Good



# Summary of findings

## What people who use the service say

We received 11 completed CQC patient comment cards and spoke with ten patients at the time of our inspection visit. We spoke with mothers with young children, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

We also looked at the results of the 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. For this practice 299 surveys

were sent out with 96 being returned, giving a response rate of 32%. The survey showed that the practice was average or higher than average amongst practices in the area:

83% of respondents found the receptionists at the practice helpful

97% of respondents said the last appointment they got was convenient

86% of respondents said the last GP they saw or spoke to was good at listening to them

78% of respondents described their overall experience of this surgery as good

## Areas for improvement

### Action the service **SHOULD** take to improve

- Improve infection control protocols and policies to support good infection control practices.
- Improve security and accountability of handwritten prescription pads

# Denton Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and three specialist advisors; a GP, a nurse and a practice manager. Our inspection team also included an Expert by Experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

## Background to Denton Medical Practice

Denton Medical Practice is situated close to Denton town centre and close to the M60 orbital motorway. At the time of this inspection we were informed 7,035 patients were registered with the practice.

The practice consisted of five GPs (three female and two male). Denton Medical Practice is a training practice and accredited by the North Western Deanery of Postgraduate Medical Education, there

and currently two trainee GPs working at the practice. The GPs are providing general medical services to registered patients at the practice under a general medical services (GMS) contract. The GPs are supported in providing clinical services by four part time practice nurses (female), a health care assistant (HCA) (female). Clinical staff are supported by two practice managers and their team who are responsible for the general administration, reception and organisation of systems within the practice.

Out of hours service is provided by Go-to-Doc.

### Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

### 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15th April 2015. During our visit we spoke with three GPs, a

nurse, both practice managers and reception staff. We also spoke with a pharmacist and two pharmacist assistants from the attached pharmacy, a member of the PPG and patients who used the service.

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

# Are services safe?

## Our findings

### Safe track record

Before visiting the practice 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. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. We looked at minutes of team meetings and confirmed that significant events and incidents were discussed and appropriately progressed. We noted that clinical and non-clinical staff were able to describe a number of significant events and how they had been investigated.

The practice had a system for dealing with safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and sent to the clinical staff for their information. One of the GPs had responsibility for managing these alerts and ensuring that all had been reviewed, progressed and finalised. The results were returned to the Practice Manager for collation, we saw email history which evidenced that this was taking place. Audits of safety alerts were planned.

### Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Significant events and changes to practice were discussed with practice staff. Action was taken to reduce the risk of recurrence in the future. The GPs completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. The Practice Managers told us that regular informal clinical meetings were held and that full staff meetings always took place monthly and the practice was closed for these events. These meetings were also the time that staff training and performance meetings took place. We looked at the minutes of these meetings and saw that they were well attended and clearly documented.

### Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3 for children) safeguarding training for those with key safeguarding roles. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly.

Practice nurses, HCAs and reception staff were available to chaperone patients who requested this service and information about this service was available in the waiting area and posted on consulting room doors. Staff had been trained in how to chaperone. When we spoke to staff they told us that they were confident in performing a role as a chaperone, and told us that the GPs would always explain in full to the patient what they were doing and why. There was a chaperone policy for staff to refer to, some clarity was required within this policy regarding whether chaperones should stand inside or outside the privacy curtain, guidance by the GMC advises that chaperones should 'stay for the whole examination and be able to see what the doctor is doing, if practicable.'

### Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of the practice nurses. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the practice internal systems. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. A system was in place for monitoring any prescriptions that had not been collected. The practice had put systems in place to account for electronically produced prescriptions; however we found two pads of unsigned prescriptions in a drawer in the

## Are services safe?

midwives room. When we asked the staff member responsible for prescription security to account for the two pads, they were unable to do so. We were told that measures would be put in place to account for and audit all prescriptions. The practice had a pharmacy located immediately next door, this made it easy for patients to collect their prescriptions and any confusion or questions relating to prescribed medicines could be quickly dealt with.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We saw that there were purpose built fridges all kept in locked rooms, equipped with locks and devices for monitoring maximum and minimum temperatures. We saw that systems were in place to check temperatures of the fridges and to effectively manage the stock contained within them.

A cold chain policy was in place to ensure that the drugs requiring storage at particular temperatures were dealt with appropriately. Staff we spoke to told us they were clear on the policy and how to implement it.

We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date.

### Cleanliness and infection control

We found the practice to be clean at the time of our inspection and patients we spoke to confirmed that this was always the case. Systems were being developed for managing infection prevention and control. We saw that a recent audit relating to infection control had been completed by the Practice Nurse with newly agreed responsibility for leading on infection control. We spoke to the Practice Manager about reviewing and updating the infection control policy, they told us it was currently being done and the lead nurse was due to attend a two day infection control training course in the very near future.

We saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant

consulting/treatment rooms. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and there was a documented protocol in place.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques. Waste bins in treatment rooms and toilets were not pedal operated and did not all have lids, the Practice Manager told us that this would be addressed. Some boxes were stored on the floor of treatment rooms making it difficult to clean thoroughly.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use; were fixed to walls and were positioned out of the reach of small children.

### Equipment

There were contracts in place for annual checks of fire extinguishers and calibration of equipment such as fridges and other electrical devices. There was no system in place for the scheduling the testing of portable appliances (PAT) of non-clinical electrical items, for example kettles, printers and computers, we discussed this with the Practice Manager and they said this would be introduced as soon as possible. Documentation evidenced that other equipment in use was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not. We looked at medical equipment that used at the practice in readiness for use and found that it was all within the manufacturers' recommended use by date. Some items required minor repair for example inspection lamps and couch roll holders in two of the treatment rooms.

### Staffing and recruitment

The provider recruitment policy was in place and up to date. We looked at three staff files and saw all of the

## Are services safe?

employment checks that were required to be carried out had been completed. The GPs had regular checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses and receptionists who carried out chaperoning duties also had DBS checks completed. Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Any sickness was closely monitored and return to work interviews were routinely completed. Support was given to staff where possible when they required it with issues related to sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand; we saw one such example of this during our inspection.

### Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported

that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy this and all other practice policies were available to all staff at any time via a shared area on the practice computers. We spoke to the practice manager about the review and version control of these policies; they told us that some attention was needed to ensure that the all policies were up to date and the most recent version available on the practice computer systems.

### Arrangements to deal with emergencies and major incidents

Basic life support training was done every year with all staff and this included using a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and fire alarm tests were completed on a weekly basis, staff we spoke to knew who the Fire Marshall was on the day of our inspection.

We saw appropriate emergency equipment and emergency drugs were available and staff knew where these could be located. We saw that emergency drugs and equipment were regularly checked by the practice nurses to ensure it was operative and within the manufacturer's recommended usage date.

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. Staff we spoke with were aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and HCAs. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance.

The practice had a system for reviewing patients with specific conditions. The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included chronic obstructive pulmonary disease (COPD), asthma, diabetes, heart disease, hypertension, rheumatoid arthritis and epilepsy. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. We saw that the practice ensured that checks on patients' blood were completed before the reviews to ensure the GP had as much information available as possible. The practice maintained a system where patients were sent recall letters to remind them about reviews; if these were not answered then staff would telephone patients to remind them.

Care plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and heart failure. We reviewed a sample of these care plans and saw they were detailed; patient centred and had been used by other health professionals to make informed decisions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all clinical staff to continually review and discuss new best practice guidelines.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff meetings and local forums where appropriate.

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved consistently high scores for QOF over recent years which demonstrated they provided good effective care to patients. QOF information indicated that patients with long term health conditions received care and treatment as expected and above the national average including, for example patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations.

### Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG audits. One audit we looked at conducted by the practice involved a review of the prescribing of anti-psychotic medicines in secondary care and how this was recorded on their clinical systems, this resulted in an update of practice systems in order to comply with Greater Manchester Medicines Management Group guidelines. Another audit completed by the practice examined the antiplatelet therapy for patients with history of ischaemic strokes; this led to a number of patients having their medication reviewed in line with NICE guidance.

The practice confirmed that peer review of clinical decision making was completed on a regular basis in clinical meetings, during case discussions at gold standard framework (GSF) meetings, during reviews of admissions avoidance and by ad hoc discussions.

# Are services effective?

## (for example, treatment is effective)

The GPs, nurses and HCAs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as end of life care and safeguarding. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice.

### Effective staffing

All the staff we spoke to at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice.

Most reception staff were long serving and they knew the regular patients well. There was an induction process for any new staff which covered areas such as the introduction to policies and procedures, confidentiality and health and safety issues.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

### Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that

information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients. The practice had dedicated members of staff for updating information on systems and scanning documents in.

### Information sharing

GPs met regularly with the practice nurses and the Practice Managers. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Managers attended CCG meetings and disseminated what they had learned in practice meetings. Regular meetings involving all team members kept staff up to date with current information around enhanced services, requirements in the community and local families or children at risk. A pharmacy was located next door and staff at the pharmacy told us of an effective working relationship and excellent communication with staff at the practice.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Managers attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Managers regularly attended area Practice Manager meetings to share information about their role and maintain their professional knowledge.

There was an informative practice website with information for patients including signposting, what clinics were available and prescription information. There was a patient participation group (PPG) established at the practice. We spoke to a member of the PPG who was very positive about the level of engagement between the practice and its patients. We noted that the minutes of the PPG meetings were not displayed for all patients to read nor did they appear on the practice website, we were told this would be addressed.

### Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers so that clinicians were aware that



# Are services effective?

(for example, treatment is effective)

consent to treatment may be an issue for consideration. A consent policy was in place at the practice and staff were able to access this via a shared area on the practice computer systems.

GPs and clinicians had received training in the Mental Capacity Act and we saw evidence from GPs that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. We looked a documented example of where one of the GPs had been involved in making a best interest decision for a patient, we saw appropriate people had been consulted and an auditable document trail had been completed.

The 2014 national GP patient survey indicated 76% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 77% said the last GP they saw or spoke to was good at involving them in decision making and 93% had confidence and trust in the last GP they saw or spoke to. These percentages were on par or above the average for the area.

## Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse or the HCA. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. Where there were issues identified that required more detailed consultation, then patients were referred to one of the GPs.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We spoke to 10 patients in person and received feedback from 11 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use in rooms during physical and intimate examinations and a chaperone service was offered, this service was clearly advertised in the waiting area and on each of the treatment room doors. Staff had received training on how to be an effective chaperone. When we spoke to staff about carrying out their role as a chaperone, they were confident about how to best perform the role.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in information security, safeguarding children and adults and information governance. We also noted that there were practice policies to cover all these areas which staff could access via a shared area on the practice computers.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 78% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 91% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were similar or higher than those for most other practices in the area.

### Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians, the practice website and prominently displayed in the waiting areas.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2014 GP patient survey reported that 77% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 83% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments. These percentages were similar or higher than most other practices in the area.

### Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and so were better able to respond to their emotional needs. We noted that HCA made regular calls to patients' homes when it was difficult for them to attend the surgery for a regular health checks. GPs told us that this was promoted by the practice as not only did it ensure checks such as blood pressure and weight were carried out regularly, it also meant that practice staff could engage with the patient in a more meaningful and compassionate manner.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or a vulnerable. We saw there was written information available for carers to ensure they understood the various avenues of support available to them.

One of the GPs took the lead for palliative care. The practice maintained a palliative care register and held regular multidisciplinary meetings with community



## Are services caring?

healthcare staff to discuss the care plans and support needs of patients and their families. We looked at minutes of these meetings and saw that they were well written and

comprehensive. Patient care plans and supporting information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, practice manager meetings, local area team meetings and meetings with Macmillan and district nurses.

Patients were able to access appointments with a named doctor. All patients over 75 had a named GP; they were able to change their named GP on request at any time. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP, many preferred to wait for a later appointment in order to see that GP. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or with more than one condition they wished to discuss. Clinical staff regularly conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for

completion of medication reviews. A documented system was in place to ensure that people who required regular reviews were contacted and a suitably long appointment was scheduled in order to meet their individual needs.

Denton Medical Practice had a reception area and sufficient consultation and treatment rooms. There were also facilities to support the administrative needs of the practice (including reception offices, practice manager's office and meeting rooms). The building was easily accessible to patients including those with a disability. We noted there was no hearing induction loop available for patients who may require one.

The practice had a PPG, one member of which we spoke to on the day of our inspection. They told us that the practice was responsive to patient needs and acted on suggestions where appropriate. The practice conducted regular patient surveys to help them gauge feeling and needs of their patient group. The last survey was conducted in November 2014, the results of which had been discussed at management meetings. The practice had shown an overall improvement in satisfaction over the past few years and recognised the value in listening to their patients.

### Tackling inequity and promoting equality

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

The practice provided information for people whose first language was not English as well as interpreter services. Some of the GPs spoke languages other than English, including Urdu and Gujarati, this had proved effective as the practice had a wide diversity of ethnicity and some consultations took place entirely in these languages. There were good communication links with the local homeless and vulnerable people service, who were able to provide information on the medical requirements of this group of people. Asylum seekers were able to register at the practice and receive the same levels of care as any other patient on production of appropriate documentation.

# Are services responsive to people's needs?

(for example, to feedback?)

## Access to the service

There were some negative comments made by patients we spoke to about being able to access appointments at the practice; the practice manager told us they were continually reviewing this area. Appointment audits were conducted on a weekly basis and adjustments made where appropriate. The practice had introduced a triage appointment system that was based on advice provided by the practice GPs; this was proving effective in ensuring that patients received an appropriate response to their requests.

We looked the results of the 2014 GP survey 83% of respondents found the receptionists at the practice helpful, 97% of respondents said the last appointment they got was convenient and 78% of respondents described their experience of making an appointment as good. These percentages were higher than other practices in the area.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday 8.00am to 6.00pm. Extended hours were operated on Saturday mornings from 8.00am to 11.30am to provide service for people who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

GP appointments were provided in ten minute time slots and were pre bookable; longer appointments were available for patients with more than one issue for discussion. Appointments could be accessed by telephone, in person or on line. Urgent appointment slots were kept available throughout the day with one of the GPs always 'on call' during surgery hours. Telephone consultations were used when appropriate. Three female and two male GPs were available at the practice and every effort was

made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The Practice Manager told us that they were constantly reviewing patient demand and appointment availability, responding to it by altering the patients booking system to ensure it was always effective.

The practice used an electronic messaging system to aid communication between administration staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service. The practice operated an effective referral system to secondary care (hospitals).

## Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both within a practice complaints and comments leaflet as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint and felt confident in doing so should the need arise.

In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review and identify any trends. We saw that complaints which were had been reviewed so that any learning and potential improvements could be identified.

# 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

There was a clear leadership structure at the practice and staff were aware of how the management structure operated and their responsibilities. Each of the GPs had specialist skills or areas of interest

which were known to staff and shown on the practice website. GPs were able to share their knowledge with the rest of team and this had proved effective in helping staff professionally develop.

We saw that the practice had a documented mission statement which included in their aims and objectives; 'Treat you with respect and courtesy at all times, provide you with advice and treatment in a timely manner, help you make decisions about your health by treating you as an equal, discuss what treatment is available and refer you on to other experts where necessary, act as your advocate and guide through health and social services, maintain confidentiality in what we discuss and the records we keep on your behalf and keep up to date with developments in health care by continuing to learn'. Staff we spoke to were unable to describe the practice mission statement but knew they formed part of a team which was aiming to provide the best care possible. We spoke to the Practice Manager and the GPs about the vision and values of the practice; they told us that they had become part of the ethos of providing the highest standards of care possible. We asked them about how the practice mission statement was formalised with staff so that they became part of their overall personal objectives. We were told that whilst not formally documented, they already formed part of the team goal of continuous improvement. The Practice Manager told us that focus would be given to making the practice mission statement more visible to staff and patients and that individual objectives to achieve the mission statement would form part of the appraisal regime in future.

### Governance arrangements

The practice held regular documented meetings for clinicians and management. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate

reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. We saw evidence that showed the GP and practice manager met with the (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. The practice had taken part in a number of CCG led initiative to improve services, for example avoiding unplanned admissions (to hospital).

The practice had a system in place for clinical audit cycles; we saw several examples of these having taken place. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits.

### Leadership, openness and transparency

Staff told us that they felt valued and well supported and knew who to go to in the practice with any concerns. The reception team had worked together for many years and had been afforded opportunities to develop both within their role and into clinical roles. The culture at the practice was one that was open and fair and this was very apparent when we spoke to staff. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw staff undertake annual appraisals and these were completed in a timely manner. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance.

The Practice Business Manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example fire safety and significant events, which were in place to support staff. Staff we spoke with knew where to find these policies if they required them for review.

# Are services well-led?

Good 

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

We were told that support for learning, development was very good. Documented peer reviews of clinical decision making were evident. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the Practice Managers. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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

The practice had gathered feedback from patients through patient satisfaction surveys, comment cards and complaints received. We looked at the results of the 2014 GP patient survey it reflected high levels of satisfaction with the care, treatment and services provided at Denton Medical Practice.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

The practice had recently appointed a quality improvement lead and instigated regular strategy meetings with the aim of improving care not only within the practice but in the wider area. The practice's QIPP ((Quality, Innovation, Productivity and Prevention) prescribing data was of such that the CCG had asked the practice to share its success with other practices in the area in order to improve overall performance.

One of the GPs was an appraiser (an experienced GP who assesses other GPs performance) for Tameside and Glossop and Stockport areas and had received specialist training in quality improvement enabling them to advise on better patient care.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with clinical staff during meetings to ensure outcomes for patients improved. We noted that the practice was very open and transparent in sharing any errors and issues of concern.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. All clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.