Park View Medical Centre

Quality Report

Park View Medical Centre
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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 Park View Medical Centre on 17 June 2015

Overall the practice is rated as good. We found the practice to be good for providing safe, effective, caring, responsive and well led services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed. Improvements in service delivery had been identified and action plans implemented to address this.
- Patients' needs were assessed and care was planned and delivered after considering best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- All patients requiring an emergency appointment were seen by the practice on the day.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice's ethos and culture respected each patient as a person with different values. The reception area was open allowing for open communication between reception staff and patients and all clinical staff walked personally to the waiting room to invite the patient into their consultation.
- The practice reviewed feedback from patients and agreed changes to the way it delivered services.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of supportive team working across all roles.

We also saw areas of outstanding practice:

- The practice worked closely, on a weekly basis with the substance misuse team to provide general medical and health care and treatment to patients. In addition, it also signposted patients to a range of support services to enable them to better manage their personal health problems.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure that clinical audits undertaken are repeated to demonstrate effectiveness of actions taken by the practice as a result of the initial audit.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and 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 was enough staff to keep patients safe.

Are services effective?

Good

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. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Written consent was obtained for minor surgical procedures. Staff benefited from annual appraisal and training appropriate to their roles. Practice nurses took lead responsibility to support patients with long term conditions and relationships were established with diabetic nurse specialists and the Acute Respiratory Assessment Service at the local NHS hospital. In addition, the practice was proactive in supporting patients by using local and national initiatives such as Expert Patient Programme, Choose to Change, Health Trainers and Fit4work.

Are services caring?

Good

The practice is rated as good for providing caring services. The physical environment and staff approach to patients promoted good respectful communication. Data showed that patients rated the practice higher than others for some 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.

Are services responsive to people's needs?

Good

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 reported good access to the practice and that there was continuity of care, with urgent appointments available the same

Summary of findings

day. The practice was committed to meeting the needs of its local population and provided services in response to this. They provided medical support to patients who misused substances, training in the speciality of domestic abuse was being undertaken and the practice was working to achieve the Pride In Practice award to support lesbian, gay, bisexual, and transgender (LGBT) patients. In addition, it also signposted patients to a range of support services to enable them to better manage their personal health problems. The practice facilities were used effectively and it was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which had quality patient care as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements were proactively reviewed. We found there was a high level of staff engagement with an open door policy for access to all senior staff. Staff told us they were very satisfied with their roles. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, the Quality and Outcomes Framework (QOF) information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was above the national average. All patients over 75 had a named GP. The practice safeguarded older vulnerable patients from the risk of harm or abuse. There were policies in place, staff had been trained and were knowledgeable regarding vulnerable older people and how to safeguard them. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average number of patients with long standing health conditions (60.5% compared to the Clinical Commissioning Group and England averages 55% and 54% respectively). Patients with long term conditions were supported by a healthcare team that cared for them using good practice guidelines and were attentive to their changing needs. Patients had health reviews at regular intervals depending on their health needs and condition. The practice maintained and monitored registers of patients with long term conditions for example cardiovascular disease, diabetes, chronic obstructive pulmonary disease and heart failure. These registers enabled the practice to monitor and review patient conditions effectively and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice supported diabetic patients by initiating insulin therapy at the practice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. The practice

Summary of findings

offered a full range of childhood vaccinations and had systems in place to follow up children who did not attend for these. Monthly meetings were held with the health visitor. A full family planning service with contraception advice and treatment was provided by the practice.

Working age people (including those recently retired and students)

Good

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 to ensure these were accessible, flexible and provided continuity of care. Online appointment and prescription ordering facilities were available and routine appointments could be booked six to eight weeks in advance. In addition, the practice was part of the federation of GPs in North Manchester and could offer seven out of hours routine appointments each week to patients who worked.

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. It had carried out annual health checks for people with a learning disability, offered longer appointments and or home visits if needed. The practice worked with multi-disciplinary teams to support vulnerable people and this included asylum seekers. A weekly substance misuse clinic was provided. A substance misuse worker from the Recovery and Integration Service (RISE) worked with the practice to provide substance misuse care, and was supported by the practice nurse and a GP to ensure these vulnerable patients received general medical and health promotion care and treatment. A designated GP was undertaking Identification and Referral to Improve Safety (IRIS) training to become a domestic abuse specialist and the practice was working to achieve the Pride In Practice award to better support lesbian, gay, bisexual, and transgender (LGBT) patients. Staff knew how to recognise signs of abuse in vulnerable adults and 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.

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 (including people with dementia). The practice recognised they had a high prevalence of patients with mental health issues and were aware of the challenges this brought. They

Summary of findings

provided care and treatment to people with enduring mental health needs and those who lived locally in care homes. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines.

Summary of findings

What people who use the service say

We received 34 completed CQC comment cards; all but one were positive about the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us that the practice environment was clean and hygienic.

During our visit, we spoke with three patients. They told us that the GPs and nurses working at the practice were very good. They told us that the GPs, the care they received and access to appointments were good. We also spoke with one member of the practice's patient participation group (PPG). They told us that the practice was trying to establish more interest and participation from the practice patient list.

In February 2015 the practice reviewed and analysed the responses they had received from the returned Friends and Family Test, feedback from the NHS Choices website and the complaints the practice had received. The result of this analysis identified key areas for further development for which an action plan was being implemented to improve these.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). For example, 86% of respondents described their experience of making an appointment as good (CCG 70%); 87% of respondents said they found it easy to get through on the phone (CCG 75%) and 71% stated they usually wait 15 minutes or less to be seen (CCG 56%).

Areas for improvement

Action the service SHOULD take to improve

- Ensure that clinical audits undertaken are repeated to demonstrate effectiveness of actions taken by the practice as a result of the initial audit.

Outstanding practice

- The practice worked closely, on a weekly basis with the substance misuse team to provide general medical and health care and treatment to patients. In addition, it also signposted patients to a range of support services to enable them to better manage their personal health problems.

Park View Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and another CQC inspector. The team included a GP and a specialist advisor who has experience of practice management.

Background to Park View Medical Centre

Park View Medical Centre is located North Manchester and is part of the NHS North Manchester Clinical Commissioning Group (CCG). Services are provided under a general medical service (GMS) contract with NHS England. According to data supplied by the practice, there are 6200 registered patients.

There are high levels of deprivation in the practice area. Information published by Public Health England, rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male life expectancy in the practice geographical area is 74 years compared with England average of 79 years and female life expectancy is 79 years compared with the England average of 83 years.

The practice opens from 8.30 am to 6 pm Monday to Fridays. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider Go To Doc. The practice also has seven routine appointments to offer to patients out of hours, provided by the federation of GPs in North Manchester.

The practice has four GP partners, two male and two female. There are two female practice nurses, one health care assistant, a practice manager, senior receptionist, and reception and administration staff.

On line services include appointment booking and ordering repeat prescriptions.

The premises are purpose built and offer access and facilities for disabled patients and visitors.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service 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 (QOF) framework 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?

Detailed findings

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection day. We carried out an announced visit on 17 June 2015.

We spoke with a range of staff including three GPs, two practice nurses, the senior receptionist, members of the reception staff, and the practice manager. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with confirmed this and said that there was an open culture at the practice. They were encouraged to report adverse events and incidents.

Minutes of meetings provided evidence that incidents, events and complaints were discussed, and where appropriate, actions and protocols identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice used a specific data collection computer programme to report significant events, incidents and complaints which were shared electronically with the Clinical Commissioning Group (CCG). The practice told us that they found this reporting tool useful, as more incidents, complaints and events were included in the newer data collection tool, which in turn enabled improved recording and monitoring. This was used to identify improvements and help learning.

We reviewed records of significant events that had occurred during the previous 12 months. Significant events were reviewed and discussed at the practice's monthly clinical meeting and where appropriate at the whole team meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Staff when interviewed told us about significant events, the outcome of investigations and resulting changes made to minimise future reoccurrence.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff confirmed they received these by email.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records that showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One staff member provided us with an example where they had referred a patient to the children's safeguarding team. Another staff member told us of an incident they observed and reported to the GP who took appropriate action. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had one GP as the lead for safeguarding vulnerable adults and one GP lead for safeguarding children. All GPs had received training to level 3 in safeguarding children. All staff we spoke with were aware of who the safeguarding leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight or flag vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible in the patient waiting room. A chaperone is a person who acts as support, as a safeguard and witness for a patient and the

health care professional during a medical examination or procedure. Reception staff carried out this duty on occasion and formal refresher training for this had been organised for later this year.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. All medicines that we checked were found to be in date.

There was a current policy and procedure in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridges remained at a safe temperature to keep vaccines and medicines at their optimal temperature. A policy and procedure for the maintenance of the cold chain was available to staff. The cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines so that they remain viable and safe to use.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. The practice acknowledged that they were behind with their reviews of medicines prescribed to patients. We saw an action plan was in place with timescales to improve this.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had recently installed electronic prescribing which meant that patient prescriptions could be sent automatically to the patient's preferred pharmacist or chemist. This reduced the need to use paper prescriptions. Blank prescription forms were stored securely.

Medicines for use in medical emergencies were securely stored in the treatment room. One practice nurse had lead responsibility for checking stocks of medicines and their expiry dates. We saw these regular checks were recorded. All staff knew where the emergency medicines were stored. There was oxygen kept by the practice for use in case of an emergency. This was checked regularly.

GPs bags also contained a small stock of emergency medicines and these were checked regularly by the practice nurse.

Cleanliness and infection control

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. We saw audits to confirm that monthly monitoring checks to ensure the practice cleanliness were carried out. Patients we spoke with told us the practice was always clean and tidy. They told us that clinical staff washed their hands and used gloves and aprons appropriately.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received training about infection control specific to their role. Records of infection control audits were available and we were told of the actions taken by the practice to improve infection control practices.

Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable in the treatment rooms and cleaned following each use.

We were told the practice only used instruments that were single use. Procedures for the safe storage and disposal of instrumentation, sharps and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a risk assessment for the management of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Good

Are services safe?

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a staff handbook available for all staff and this was supported by a set of health and safety, general workplace and clinical policies and procedures for staff follow.

The practice had invited the Information Commissioner's Office (ICO) to the practice to assess the standard of information governance undertaken by the practice. Following the visit in February 2015 a report identified areas of good practice and areas for improvement. At our visit, we could see the action taken in response to the report and information held on paper and electronically was stored securely.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment checks and fire drills to ensure the safety of patients, staff and visitors were available.

Arrangements to deal with emergencies and major incidents

Staff described how they would alert others to emergencies by use of the panic button and on the computer system.

A comprehensive business continuity policy was in place. This covered all aspects of potential risks to business continuity including staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity policy and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use.

Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us clinicians listened to them and they were confident in the treatment they received. All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

The local community where Park View Medical Centre had been classified as having high levels of multiple deprivation. (Multiple deprivation is when different types of deprivation e.g. lack of education, poor health, high crime levels, high unemployment are combined into one overall measure of deprivation, and are indicators of the quality of life that the local population experience). We found clinicians and staff were familiar with the needs of their local population and the impact of the socio-economic environment on their health and wellbeing. National data showed that the practice had 1.4% of its population living in nursing homes compared to the England and Clinical Commissioning Group (CCG) average of 0.5% Data also showed the proportion of patients with a long standing health condition was 60.3% compared with the England average of 54%. The practice told us that 89% of its population was under the age of 65; 30% were from a black or ethnic minority background and enduring mental health prevalence was 2.8%.

The GPs and practice nurses had completed accredited training for checking patient's physical health and the management of various specific diseases. The GP partners told us they shared the clinical and corporate governance between them and all GPs supported the practice nurses to deliver their responsibilities in specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma. GPs were also proactive in taking the lead for additional specialities such as alcohol and substance misuse and training was being undertaken to provide a domestic abuse specialist service.

Clinical staff told us the practice focused on learning and developing to improve outcomes for patients. They said they were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long-term health conditions. Both practice nurses told us that they were supported by the GPs and they felt able to discuss any concerns they had about a patient or the management of a patient's condition. We heard that updated guidance and research in relation to managing diabetes and the associated health care needs was implemented following regular review. For example, the practice supported Type 2 diabetic patients to start on insulin treatment. Traditionally injectable treatment for Type 2 diabetes was managed by specialist diabetes services.

The practice had used an electronic database to record patient information. One of the practice nurses had developed and amended information templates to make it easier and quicker for clinicians to record patient's information, add alerts and link to the appropriate read code within the clinical record system. This ensured that patients with specific needs were highlighted on opening the clinical record and enabled all clinical staff to offer patients opportunistic screening or vaccinations when they visited the practice for another reason.

Systems were in place to ensure all test results and hospital consultation letters received into the practice were reviewed by a GP. All results and letters were scanned onto the system daily.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular audits. Annual QOF data showed the practice had consistently performed better than the CCG and England average between 2010 and March 2014. Their score for 2014 was 96.6% compared with the CCG 89.8% and the England average of 94%. Clinical staff told us that each team member took responsibility to opportunistically offer patients outstanding clinical assessments.

The practice was aware of the challenges the practice population created in meeting some QOF targets such as cervical screening. In response to this, the practice was piloting an alternative screening method that allowed the

Good

Are services effective?

(for example, treatment is effective)

patients to carry out their own swab test, which was then sent away for analysis. The swab test is used to detect the presence of human papilloma virus (HPV) which is a recognised risk factor for developing cervical cancer.

GPs and a practice nurse told us about the clinical audits undertaken, however some of the audits we looked at, had not been repeated, which meant the impact or effectiveness of the audit could not be analysed. We were told that the GPs usually kept their own clinical audits for use for their appraisal but these would in future be accessible on the practice's shared drive so that any learning from these was shared.

The practice worked with other GP practices within the CCG and participated in monthly integrated care multidisciplinary teams meetings to discuss the care and support needs of patients and their families in the local neighbourhood. Minutes from these meetings were available. Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff were overwhelmingly positive and enthusiastic about working at the practice. They told us that the patient was central to the services they provided and were clear how their work contributed to and impacted overall on the service provided. They said they felt involved, supported and trained to provide a good standard of service to patients.

We reviewed staff training records and saw that these were comprehensive. All staff had access to a staff handbook which included a range of employment policies and procedures and included information on safeguarding and whistleblowing. Staff were up to date with attending mandatory courses such as annual basic life support.

The practice manager had reviewed staff training and carried out a training analysis. The training analysis and audit of training records had identified gaps in staff training and the records of this. As a result, the practice manager had planned a full staff training day that all staff would attend to provide a baseline. All staff undertook annual appraisals that identified learning needs from which action plans were documented.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries and information from out-of-hours GP services both electronically and by post. Relevant staff knew their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

There were well established working relationships with other health care professionals such as the diabetic nurse specialists and the Acute Respiratory Assessment Service at the local NHS hospital.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings. We saw a variety of documented meetings between the staff teams, which confirmed good working relationships between them and good review and joint decision making in patient care.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

All clinical staff we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. Staff told us that training for this and the Deprivation of Liberty Safeguards had been arranged. Copies of the MCA Code of Practice were available in the GP consultation rooms. Staff gave us examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained and documented in the patient notes. Implied consent was obtained for insertion of intrauterine devices (IUD) and child immunisations with documentation of explanation and consent obtained in the records.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients about the services available via their website and in leaflets and posters in the waiting area. This included smoking cessation, obesity management and travel advice.

The practice nurses held a variety of clinics including a weekly baby clinic and a clinic for specific problems and general health checks. The practice offered mixed clinics and a specific health clinic for diabetic patients. The health care assistant provided a lifestyle management support service to patients. This included discussions about the patient's environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency. The practice also operated NHS health checks for patients between 40-74 years of age. In addition, the practice was proactive in supporting patients by using local and national initiatives such as Expert Patient Programme, Choose to Change, Health Trainers and Fit4work.

The practice worked with multi-disciplinary teams to support vulnerable people and this included asylum seekers. A weekly substance misuse clinic was provided at the practice. A substance misuse worker from the Recovery and Integration Service (RISE) worked with the practice to provide substance misuse care, and was supported by the practice nurse and a GP to ensure these vulnerable patients received general medical and health care and treatment. A designated GP was undertaking Identification and Referral to Improve Safety (IRIS) training to become a domestic abuse specialist and the practice was working to achieve the Pride In Practice award to better support lesbian, gay, bisexual, and transgender (LGBT) patients.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed well, when compared with the average results for the local Clinical Commissioning Group (CCG). 86% of respondents described their experience of making an appointment as good (CCG 70%); 87% of respondents said they found it easy to get through on the phone (CCG 75%) and 71% stated they usually wait 15 minutes or less after their appointment to be seen (CCG 56%).

The three patients and one member of the patient participation group (PPG) all told us that the GPs and nurses working at the practice were very good. They told us that the GPs, the care they received and access to appointments were good. Patients particularly liked the being able to see a GP if they needed to in an emergency. The comments from patients were reflected in the detailed responses recorded on many of the 34 CQC comment cards we received.

In February 2015 the practice reviewed and analysed the responses they had received from the returned Friends and Family Test (the Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience of the GP service they receive), feedback from the NHS Choices website and the complaints the practice received. The analysis identified key themes and an action plan was being implemented to improve the identified areas. These included increasing the numbers of patients completing the Friends and Family Test, seeking solutions to respond effectively to anonymous but specific patients concerns and planning adjustments to the building to include a designated area in the reception for patient's to discuss issues more privately, away from the main waiting room.

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The reception desk was open and accessible and this staff said allowed for better and more open communication with patients and promoted positive relationships. The computers at reception were shielded from view for confidentiality and staff took patient phone calls away from the main reception area to avoid being overheard.

Consultations took place in rooms with an appropriate couch for examinations and screens to maintain privacy and dignity. We observed staff were discreet and respectful to patients. The GPs walked out to personally call patients into their consultation. This behaviour underpinned the practice ethos of respectful patient centred care. The patients we spoke with told us they were always treated with dignity and respect.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 87% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments, 92% said they had confidence and trust in the last GP they saw or spoke to and 99% had confidence and trust in the last nurse they saw or spoke to.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback on the comment cards we received indicated they felt listened to and supported.

The practice told us that all patients over 75 years had a named GP and care plans were in place for patients with dementia and unplanned admissions to hospital. In addition, care plans were available for some diabetic patients (diabetes personal prescription care plan) to help them with managing their diabetes.

Some staff could speak languages beside English and access to translation services was available for patients who did not have English as a first language. Double appointments were provided when translation services were required. The practice had a diabetic information leaflet available in Urdu and information on the practice website was available in a range of different languages.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations. Detailed information was also available on the practice's website about a range of support services that patients could access. Their website also contained a section for 'Family Health', 'Long term Conditions' and 'Minor illnesses'.

Good

Are services caring?

Systems were in place to keep reception staff aware of those patients nearing end of life so that in the event of a telephone call the appropriate GP was notified immediately. The practice routinely contacted recently bereaved patients about one month after the bereavement to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice monitored the service it provided and listened to patients. It was responsive to patients' needs and evidence was available demonstrating it was adapting to improve and maintain the level of service provided. For example, GPs were undertaking additional training in specialities such as domestic abuse and they were working to achieve the Pride In Practice award to better support lesbian, gay, bisexual, and transgender (LGBT) patients.

The practice held information and registers about the prevalence of specific diseases within their patient population. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions and mental health conditions.

Patients with dementia, learning disabilities and enduring mental health conditions were reviewed annually. The practice also supported patients who had enduring mental health needs and lived in care homes and supported accommodation. They had implemented the 'named GP' for patients over 75 to support continuity of care. The practice was proactive in contacting patients who failed to attend vaccination and screening programmes and when patients did attend the surgery the clinical staff offered opportunistic screening to make sure patients received the checks their health care needs required. A weekly substance misuse clinic was provided. A worker from the Recovery and Integration Service (RISE) worked with the practice to provide substance misuse care, general medical and health promotion care and treatment. In addition, local and national resources to support patients with their health care were used and included the Expert Patient Programme, Choose to Change, Health Trainers and Fit4work.

The practice had an active Patient Participation Group (PPG), which was working with them to recruit patients to join from the black and ethnic minority communities. Members of the PPG had also supported the practice by spending time with patients to show them how to complete the Friend and Family Test electronically.

Tackling inequity and promoting equality

The practice building was purpose built some years ago. It was, we heard constructed so that if the practice facilities needed to expand then the foundations would accommodate this. All treatment and consultation rooms were on the ground floor. The building provided disabled access into the reception and waiting areas. Disabled toileting facilities were available.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice population's needs and provided a good service to all patient population groups. Staff we spoke with gave examples of where they provided tailored information to patients to support their cultural and religious needs.

Staff told us they had access to translation services and provided examples where they ensured an interpreter was available for patients at their appointments.

Staff spoken with were aware of the patients on their register who were also asylum seekers.

Access to the service

The practice was open Monday to Friday 8.30 am until 6.00 pm. The practice website and practice information booklet contained details about who to contact for advice and appointments out of normal working hours and the contact details for the out of hours medical provider. The practice offered a range of appointments each day. This included pre bookable appointments, which could be booked up to eight weeks in advance and on the day emergency appointments. Patients could ring for an emergency appointment or telephone consultation each day and they were guaranteed an appointment. The patients we spoke with, CQC comment cards and the GP patient survey data all indicated that patients were satisfied with this level of access. The results of the National GP Patient Survey published in January 2015 showed that 94% of patients said the last appointment they got was convenient, 86% described their experience of making an appointment as good and 91% described their overall experience of the surgery as good.

In addition, the practice was part of a federation of GPs in North Manchester and offered seven out of hours routine appointments each week to patients.

Appointments with the practice nurses were tailored to meet the needs of patients, for example, those with long

Good

Are services responsive to people's needs?

(for example, to feedback?)

term conditions and those with learning disabilities were given longer appointments. The practice nurses also undertook home visits to older patients and those vulnerable housebound patients.

Listening and learning from concerns and complaints

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

We looked at the records of the nine complaints received by the practice between June 2014 and May 2015. We saw the practice responded to complaints proactively; investigating the concern, responding appropriately to the complainant, identifying improvements in service quality, sharing learning and adapting practice. Staff spoken with verified that they were consulted and made aware of changes in procedures as a result of complaint investigations.

Information for patients on how to make a complaint was included in the practice leaflet and on their website.

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

The practice had a clear vision to support patients to stay healthy and to provide a high quality, patient centred care to them if they were unwell. Their ethos included, "To focus on patient centred care always" and "Our care will be holistic and respectful of patient's ideas and personal values". We saw the practice environment promoted this ethos in that the reception area was open and patients could communicate easily with staff without glass partitions. We heard this promoted positive relationships between staff and patients. In addition, all clinical staff walked personally to the waiting room to invite the patient into their consultation.

We saw that the GPs worked together to develop both short term and longer term practice development plans and these were shared with all staff. Staff we spoke with understood the practice vision and values and felt part of the team. They were committed and enthusiastic about working at the practice.

Governance arrangements

There was a clear organisational and leadership structure at the practice with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer shared drive and in hard copy if required. Policies and procedures we viewed were dated and reviewed appropriately and were up to date. Staff confirmed they had read them and were aware of how to access them.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed consistently better than the Clinical Commissioning Group (CCG) and the England average for the last four years. The practice also monitored other data sources to benchmark performance and where issues were identified initiated action to improve.

Staff undertook a range of audits regularly. However, completion of two full clinical audit cycles was not always evident. Minutes of clinical meetings provided clear evidence that the outcome of the audits were discussed at team meetings.

Risk assessments and risk management plans were in place.

Leadership, openness and transparency

There was a well-established clearly identified management structure with clear lines of responsibility. We spoke to staff with differing roles within the service and they were clear about the lines of accountability and leadership. They all spoke of good clear leadership that articulated vision and motivated staff to provide a good service.

Staff felt well supported in their role. They felt confident in the senior team's ability to deal with any issues, including serious incidents and concerns regarding clinical practice. All the staff we spoke with told us they felt they were valued and their views about how to develop the service acted upon.

The practice held a number of different meetings at regular intervals that were documented. These included clinical, administrative, organisational, managerial and business meetings. Examples of various meeting minutes demonstrated information exchange, improvements to service, practice developments and learning from complaints and significant events.

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

Complaints were well managed. The practice investigated and responded to them in a timely manner. These were discussed at staff meetings and were used to ensure staff learned from the issues identified when appropriate.

There was a small active Patient Participation Group (PPG). Action was being taken by the practice and the PPG to encourage more interest and increase the membership especially from patients from different ethnic backgrounds to better reflect the registered patient population.

Are services well-led?

Good

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

The practice had a staff feedback box and they confirmed that action was taken to any concerns they raised. This they felt was positive and productive. There was a whistleblowing policy in place. Staff told us they had no concerns about reporting any issues internally. They gave examples of reporting incidents openly and believed there was a no-blame culture at the practice, which encouraged reporting and evaluation of incidents and events

Management lead through learning and improvement

The practice worked well together as a team and held meetings for learning and to share information. The practice worked with the CCG to develop and improve services both for the practice and the wider locality. The practice was aware of and acting on areas that needed improving in their service delivery.

GPs were all involved in revalidation, appraisal schemes and continuing professional development. We saw that staff were up to date with annual appraisals, which included looking at their performance and development needs.

The practice had an induction programme for new staff and a programme of mandatory training was in place for all staff. The practice manager had recently carried out a review of staff training and the records of this. Following this review, the practice manager had put an action plan in place to ensure all staff were trained appropriately and this was recorded effectively. Staff told us they had good access to training and support to undertake further development in relation to their role.

The practice recognised future challenges and areas for improvement, had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.