

Dr Richard Clare

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

The practice of Dr Richard Clare was inspected on the 22 January 2015. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We rated the practice as good in relation to being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice.

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. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Patients informed us that their privacy and dignity was always respected particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation room.

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 meet patient's needs.

The practice had gathered feedback from patients through the yearly practice patient survey and comments and complaints received. We looked at the results of the January 2015 GP patient survey and the survey conducted by the practice in December 2014. Both of these reflected high levels of satisfaction with the care, treatment and services provided. However where issues were identified action had been taken to address them.

We saw areas of outstanding practice including:

The practice provided a GP service for three residential accommodation facilities for patients with severe and

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enduring mental illness. To maximise the support provided the practice team had developed effective working relationships with the mental health workers in Sale and where appropriate carried out joint visits to see patients.

The practice worked closely with Trafford learning disabilities team. For example they had recently worked with them to organise day care respite and physiotherapy within the learning disability team where mainstream services were unable to accommodate the patient.

The lead GP and senior members of the practice team described to us a clear value system which provided the

foundations for ensuring the delivery of a high quality service to patients. They took pride in the practice being very much a traditional family practice, describing how knowledge of patients and their families had been built up over many years which resulted in a strong trusting relationship which greatly enriched the patient experience.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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. Patient's 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 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 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 several 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.

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 and Trafford Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they 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 been seeking to improve the environmental facilities and was well

Good



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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. Learning from complaints with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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. The patient participation group (PPG) was active. 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.

Good



People with long term conditions

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

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. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively 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 and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 had carried out annual health checks for people with learning disabilities and offered longer appointments for people with learning disabilities. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations and had arranged for a welfare benefits advisor to be accessible at the practice once a week. 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 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 had carried out annual health checks for people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations such as MIND. The practice had a system in place to follow up on patients who did not attend practice appointments or had attended accident and emergency where there may have been mental health needs.

Good



Summary of findings

What people who use the service say

We received 17 completed CQC comment cards, spoke with five patients on the day of inspection and three members of the practice's patient participation group (PPG) prior to our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards expressed their satisfaction about the treatment and care provided by the doctors and nurses and their experience of contact with the practice team generally. They also told us that their privacy and dignity was maintained and they were treated with respect. The representatives of the PPG told us they met with the practice management team regularly and that views were listened to, respected and valued.

We also looked at the results of the GP patient survey published in January 2015. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

What this practice does best;

97% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. (Local CCG average: 83%).

98% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care. (Local CCG average: 86%).

98% of respondents were able to get an appointment to see or speak to someone the last time they tried. (Local CCG average: 87%).

What this practice could improve;

73% of respondents find it easy to get through to this surgery by phone. (Local CCG average: 81%).

72% of respondents describe their experience of making an appointment as good. (Local CCG average: 78%).

65% of respondents usually wait 15 minutes or less after their appointment time to be seen. (Local CCG average: 70%).

254 surveys sent out. 116 surveys back. 46% completion rate.

We also looked at the results of the practice's friends and family test for December 2014. There had been 19 responses;

15 were extremely likely to recommend the practice to friends and family.

3 were likely to recommend the practice to friends and family.

1 was extremely unlikely to recommend the practice to friends and family.

The practice also commissioned an independent patient survey each year. We looked at the results for the most recent survey published in December 2014. These reflected high levels of patient satisfaction with the care and treatment provided at the practice. The survey also identified issues of concern to patients such as difficulties getting through to the practice by telephone in the mornings, the need for shorter waiting times and the difficulties experienced with the current premises.

Outstanding practice

The practice provided a GP service for three residential accommodation facilities for patients with severe and enduring mental illness. To maximise the support provided the practice team had developed effective working relationships with the mental health workers in Sale and where appropriate carried out joint visits to see patients.

The practice worked closely with Trafford learning disabilities team. For example they had recently worked with them to organise day care respite and physiotherapy within the learning disability team where mainstream services were unable to accommodate the patient.

The lead GP and senior members of the practice team described to us a clear value system which provided the foundations for ensuring the delivery of a high quality

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service to patients. They took pride in the practice being very much a traditional family practice, describing how

knowledge of patients and their families had been built up over many years which resulted in a strong trusting relationship which greatly enriched the patient experience.

Dr Richard Clare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector and a specialist GP advisor. Our inspection team also included an Expert by Experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dr Richard Clare

The practice of Dr Richard Clare is situated in the Sale area of Trafford. At the time of this inspection we were informed 4,471 patients were registered with the practice. This is a 9% increase in the number of patients registered since 2012. This increase in numbers (due to demographic changes within the boundaries of the practice, changes to the actual boundaries of the practice and the limitations the practice environment currently presents) has resulted in the practice (following consultation with NHS England) reaching current capacity and reluctantly ceasing to register new patients for a nine month period (beginning 1 October 2014). The practice has been actively seeking for some time to improve patient access by extending the current building to facilitate this.

The practice population experiences lower levels of income deprivation affecting children and older people than the practice average across England. There is also a higher proportion of patients above 65 years of age (17.6%) than the practice average across England (16.53%). The practice has a slightly higher proportion of patients under 18 years

of age (21.4%) than the practice average across England (20.9%). 43.9 per cent of the practice's patients have a longstanding medical condition compared to the practice average across England of 53.54%.

At the time of our inspection 1 full time GP (male), 1 part-time salaried GP (female) and 1 locum GP (female) were providing general medical services to patients registered at the practice. The GPs are supported in providing clinical services by 2 practice nurses (female). Clinical staff are supported by the nine staff in the practice team. This team includes and are led by the practice management team comprising of the practice manager, a clinical development manager and a business manager.

The practice of Dr Richard Clare contracts with NHS England to provide General Medical Services (GMS) to the patients registered with the practice.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider (Mastercall). The practice website provides patients with details of how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

Why we carried out this inspection

We inspected this service as part of our new 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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

- 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 the 22 January 2015 and spent seven and a half hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received 17 completed CQC comment cards, spoke with five patients at the time of our inspection and three members of the practice's patient participation group (PPG) prior to our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with the full time GP who is the registered provider, the part-time salaried GP, one of the practice nurses, three of the practice management staff and two members of the practice team who were working at the time of our visit.

Are services safe?

Our findings

Safe Track Record

There were clear lines of leadership and accountability in respect of how significant incidents (including mistakes) were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and Trafford Clinical Commissioning Group (CCG)) to share what they knew. No concerns were raised about the safe track record of the practice. Discussions with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. Learning was based on a thorough analysis and investigation of things that go wrong. All staff were encouraged to participate in learning and to improve safety as much as possible. Opportunities to learn from external safety events were identified. We spoke with staff from across the practice team. They told us that the culture at the practice was fair and open and that they were encouraged to report incidents and mistakes and were supported when they did so. The learning from significant events was discussed at the monthly practice meetings. We looked at records relating to how the practice team learnt from incidents and subsequently improved safety standards. The examples we looked at showed how incidents were investigated by defining the issue clearly and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again.

The practice had a system for managing safety alerts (from external agencies). These were emailed to the GPs and practice nurses and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. We were informed that one of the GPs took the lead on safeguarding children and their GP colleague took the lead for safeguarding vulnerable adults. Their roles included providing support to their practice colleagues for safeguarding matters and liaising with external safeguarding agencies, such as the local social services and CCG safeguarding teams and other health and social care professionals as required. We discussed how safeguarding was managed at the practice and looked at the systems used to ensure patients safeguarding needs were addressed.

The systems highlighted to the GPs and practice nurses when a safeguarding issue or safeguarding plan had been identified and developed for individual patients. We also saw that the practice team were communicating regularly with the safeguarding leads for children and adults at Trafford social services and Trafford CCG when required and provided reports to them when requested to do so. Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. We saw evidence that one of the GPs had received enhanced (level 3) children's safeguarding training and arrangements had been made for another GP to access that training at the end of January 2015 (we were provided with evidence following our visit that this training had been completed).

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. Staff were provided with training to ensure that chaperoning was safe and effective. No issues in respect of chaperoning were raised by patients we spoke with or received information from.

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 clinical staff at the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions. It was established practice to monitor the

Are services safe?

amount of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicine errors were treated as significant events. 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 found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained. 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 & Infection Control

We looked around the practice during our visit. Systems were in place for to ensure the practice was regularly cleaned. We looked at records that reflected a cleaning schedule and a risk assessment process was in place. We found the practice to be clean at the time of our visit. A system was in place for managing infection prevention and control. One of the practice nurses provided leadership in this area. Staff had been provided with regular infection prevention and control training and this included the use of appropriate hand washing techniques. We saw that appropriate hand washing facilities (including liquid soap and disposable towels) and instructions were available throughout the practice. Checks (audits) had been conducted to ensure actions taken to prevent the spread of potential infections were maintained. The last audit had identified some action points and we established these had been addressed.

We also 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.

We looked at the three consulting/treatment rooms. These rooms were clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste was stored safely and securely in specially designated bags before being removed by a specialist company for safe disposal. We saw records that detailed when such waste was removed.

Equipment

A record of maintenance of clinical, emergency and other equipment was in place and it was recorded when any items were repaired or replaced. We saw that all of the equipment had been regularly tested and the practice had contracts in place for personal appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration of equipment.

Staffing & Recruitment

The practice was staffed to enable the general medical service needs of patients to be met. We were informed by senior staff at the practice that they had recently reviewed their staff mix, numbers and configuration to meet the changing and increasing demands on the services provided. A system was in place to plan surgery times that ensured a GP was available for all the sessions. Records we looked at indicated that the practice used the services of locums who were familiar to the practice and therefore known to the permanent GPs wherever possible.

We looked at staff recruitment practices and records. A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body, for example The General Medical Council (GMC). Also a Disclosure and Barring Service (DBS) check had been conducted to assess the person's suitability to work with potentially vulnerable people.

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all clinical practice staff received annual basic life support training. Non-clinical staff received such training every three years. We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks,

Are services safe?

including disruption to staffing or facilities at the practice. The plan had been developed in conjunction with Trafford CCG and identified two local 'buddy' practices that would provide support in the event of an emergency or major incident occurring.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE) and guidance published by professional and expert bodies. We saw that such standards and guidelines were easily accessed electronically by clinicians.

Discussion with the lead GP and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff were conducting consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

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.

The practice had a system in place for completing clinical audit cycles. These were 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. We saw three recent examples of these at the practice relating to diabetes medicines and dizziness in the elderly, measuring vitamin B12 levels in patients who are prescribed metformin and the prescribing of certain medicines for patients receiving aspirin or anticoagulant medicines. All had been completed in accordance with the clinical audit cycle.

We saw evidence of individual peer review and support and monthly practice meetings being held to discuss issues and

potential improvements in respect of clinical care. Practice meeting minutes we looked at demonstrated how the actions to make improvements taken were monitored over time to ensure they were embedded and effective.

The GPs, practice nurses and administration staff had developed areas of expertise and took 'the lead' in a range of clinical and non-clinical areas such as infection prevention and control and safeguarding children and vulnerable adults. They provided advice and support to colleagues in respect of their individual area.

There were care plans in place for patients with more complex conditions and at risk of unplanned admissions to hospital. These were regularly reviewed by the clinical staff. Unplanned admissions were also followed up by the clinical staff as soon as possible after the patient's discharge to minimise the risk of re-admission.

An ante-natal clinic was provided at the practice by a community midwife every Thursday morning. Discussion with the midwife and the practice team demonstrated they worked closely together to ensure women attending the clinic could access other medical support such as immunisation.

A phlebotomy (the taking of blood samples) service was provided by the Practice nurses thereby preventing patients having to attend the local hospital for routine blood tests.

The practice had a significant percentage of patients in care homes in the Sale area necessitating almost daily visits from clinicians. The practice was currently working with Trafford CCG to see how this provision could be more effectively provided in the Sale 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. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Effective staffing

The practice team comprised of clinical and non-clinical staff. At the time of our inspection 1 full time GP (male), 1 part-time salaried GP (female) and 1 locum GP (female) were providing general medical services to patients registered at the practice. The GPs were supported in providing clinical services by 2 practice nurses (female).

Are services effective?

(for example, treatment is effective)

Clinical staff were supported by the nine staff in the practice team. This team included and were led by the practice management team comprising of the practice manager, a clinical development manager and a business manager.

Staff training records and discussions with staff demonstrated that all staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. New staff were provided with a programme of induction that included training relevant to their role. We saw that regular appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff we spoke with said they being supported to access relevant training that enabled them to effectively carry out their role.

The GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. Both the GP's had undergone recent clinical appraisals and revalidation. The practice nurses were supported to attend training updates that enabled them to maintain and enhance her professional skills.

Working with colleagues and other services

Arrangements were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear systems to make such referrals in a timely way and to ensure patients receive effective, co-ordinated and integrated care. Referrals were assessed as being urgent or routine. Patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed with them and they were given enough information to make informed choices. The practice had established and developed links with the integrated care programme in Trafford.

The practice provided a GP service for three residential accommodation facilities for patients with severe and enduring mental illness. To maximise the support provided the practice team had developed effective working relationships with the mental health workers in Sale and where appropriate carried out joint visits to see patients.

The practice also worked closely with Trafford learning disabilities team. For example they had recently worked with them to organise day care respite and physiotherapy within the learning disability team where mainstream services were unable to accommodate the patient.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings with professionals to discuss child health and safeguarding issues, and with McMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hours service. The practice provided detailed clinical information to the out of hours service about patients with complex healthcare needs. Also all patient contacts with the out of hours provider were reviewed by a GP the next working day.

A system was in place for hospital discharge letters and specimen results to be reviewed by the GP who would initiate the appropriate action in response.

Information sharing

All the information needed to plan and deliver care and treatment was stored securely (electronically) but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples of this when looking at how information was shared with Trafford local authority and Trafford CCG safeguarding teams.

Consent to care and treatment

Patients we spoke with told us that they were communicated with 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 January 2015 GP patient survey reflected that 97% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 93% said the last GP they saw or spoke to was good at explaining tests and treatments and 97% say the last nurse they saw or spoke to was good at explaining tests and treatments.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Where people lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with legislation. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and of supporting those who did not have the mental capacity to make a decision in relation to their care and treatment.

Clinical staff demonstrated a clear understanding of the Gillick competencies. (These help clinicians to identify children under 16 who have the capacity to consent to medical examination and treatment).

Health promotion and prevention

Whilst new patients were not being registered at the time of our visit we established that a system was in place to ensure when patients were being registered all new patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to quickly identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma.

A wide range of health promotion information was available and accessible to patients particularly in the patient waiting area of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation and influenza vaccinations were provided.

The provision of health promotion advice was an integral part of each consultation between clinician and patient. Patients were also enabled to access appropriate health assessments and checks.

A system was in place to provide health assessments and regular health checks for patients when abnormalities or long term health conditions are identified. This included sending appointments for patients to attend reviews on a regular basis. When patients did not attend this was followed up to determine the reason and provide an alternative appointment.

Patients were provided with fitness to work advice to aid their recovery and help them return to work.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received seventeen completed CQC comment cards, spoke with five patients and also spoke with three members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs. Information we received from patients reflected that practice staff interacted with them positively. They told us that staff at the practice treated them politely and as an individual and with respect.

Our discussions with staff revealed a strong, visible, person-centred culture was valued and promoted by them. Staff were motivated and inspired to offer care that was kind and promotes people's dignity. They told us that the relatively small size of their patient list enabled them to ensure relationships between patients, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff we spoke with and were promoted by the lead GP and senior practice staff. Staff were observed to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us that their privacy and dignity was always respected maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation rooms. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided.

Staff we spoke with said that if they witnessed any discriminatory behaviour or where a patient's privacy and dignity was not respected they would be confident to raise the issue with senior practice staff. We saw no barriers to patients accessing care and treatment at the practice.

We looked at the results of the January 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results reflected that

97% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 97% of respondents said the last nurse they saw or spoke to was good at listening to them.

Care planning and involvement in decisions about care and treatment

The January 2015 GP patient survey reported that 97% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 98% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon.

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

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment the practice had taken action to address this. For example language interpreters were readily accessed (by telephone) and extended appointment times were provided to ensure this was effective.

Patient/carer support to cope emotionally with care and treatment

Discussion with staff and patients demonstrated that there was a person centred culture at the practice where the staff team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patient's care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patients carers.

A wide range of information about how to access support groups and self help organisations was available and accessible to patients from the practice clinicians and in the reception area.

A counselling support service was also available to provide emotional support to patients following referral by a GP.

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 meet patient's needs.

Patients were able to access appointments with a named doctor where possible. 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 who were carers. Home visits were provided to patients whose illness or disability meant they could not attend an appointment at the practice.

The GPs and practice nurses had developed areas of special interest and expertise and took 'the lead' in particular clinical areas. These clinical areas included considering the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Arrangements 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 activity analysis was shared with Trafford CCG and formed a part of the quality outcome monitoring. It also assisted the clinical staff at the practice to check that all relevant patients had been called in for a review of their health conditions and medication.

Systems were in place to identify when people's needs were not being met and informed how services at the practice were developed and planned. A variety of information was used to achieve this. For example profiles of the local prevalence of particular diseases, the level of social deprivation and the age distribution of the population provided key information in planning services.

Significant events analysis, individual complaints, survey results and clinical audits were also used to identify when patients needs were not being met. This information was then used to inform how services were planned and developed at the practice.

The practice has a reception area, a patient waiting area and three consultation and treatment rooms. There were also facilities to support the administrative needs of the practice including a reception area. The GPs consulting room are on the ground floor of the premises and the nurse consulting room is on the first floor. There is no passenger lift at the practice. Patients with an appointment to see a nurse, who are unable to negotiate the stairs, were always seen in one of the ground floor consulting rooms. The senior practice team were acutely aware of the constraints and challenges the current premises pose to providing services to patients. We saw documentary evidence that they have submitted a capital bid to NHS England to reconfigure the current premises to provide more suitable additional clinical and office space to manage the increasing workload. We understand that the practice continues to engage with NHS England and Trafford CCG to progress this matter.

Tackling inequity and promoting equality

Action had been taken 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 services that were individualised and responsive to individual needs 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, dementia and mental health needs. For example appointments for patients with learning disabilities were made available outside of routine surgery times to allow the time necessary to undertake a full health assessment and minimising distress and upset to the patient. The practice had received very positive feedback from the patient's families regarding this. Also where patients with mental health needs turned up late for appointments they endeavoured to still see and support them.

Access to the service

We received seventeen completed CQC comment cards, spoke with five patients and also spoke with three members of the practice's patient participation group

Are services responsive to people's needs?

(for example, to feedback?)

(PPG). We spoke with patients from various age groups and with people who had different health care needs. Patients generally commented positively in respect of being able to access the service. We also looked the results of the January 2015 GP survey. 73% of the respondents found it easy to get through to the practice by phone. 98% were able to get an appointment to see or speak to someone the last time they tried and 97% said the last GP they saw or spoke to was good at giving them enough time. Also 89% said the last appointment they got was convenient and 72% described their experience of making an appointment as good.

The opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas, the practice web site and were also contained in the practice information leaflet readily available to patients in the reception area. The senior practice team informed us that agreement had been reached to provide an extra 2.5 hour of appointments to improve patient access. There were also 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. Information on the out-of-hours service was provided to patients. This information was also available on the practice web site.

GP consultations were provided in 10 minute appointments. Where patients required longer appointments these could be booked by prior arrangement. A system was in place for patients who required urgent appointments to be seen the same day. Patients accessed appointments by telephone as the practice did not have a web site.

At the time of this inspection we were informed 4,471 patients were registered with the practice. This was a 9% increase in the number of patients registered since 2012. This increase in numbers (due to demographic changes within the boundaries of the practice, changes to the actual boundaries of the practice and the limitations the practice environment currently presents) has resulted in the practice (following consultation with NHS England) reaching current capacity and reluctantly ceasing to register new patients for a nine month period (beginning 1 October 2014). The practice had been actively seeking for some time to improve patient access by extending the current building to facilitate this.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web-site. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

We looked at three complaints received in the last twelve months. In line with good practice all complaints or concerns were recorded and investigated. The complaints record detailed the nature of the complaint, the outcome of the investigation and how this was communicated to the person making the complaint. Discussion with staff and minutes of staff meetings demonstrated that learning from complaints was discussed at monthly staff meetings to identify how improvements to the service could be made.

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 well-established leadership structure with clear allocation of responsibilities amongst the GPs and the practice team. We saw evidence that showed senior practice staff engaged with and met with the Trafford Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

The lead GP and senior members of the practice team described to us a clear value system which provided the foundations for ensuring the delivery of a high quality service to patients. They took pride in the practice being very much a traditional family practice, describing how knowledge of patients and their families had been built up over many years which resulted in a strong trusting relationship which greatly enriched the patient experience.

The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients generally demonstrated this perception of the practice was widely shared.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to challenge existing arrangements and improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve the quality of the services provided.

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

The practice had a system in place for completing clinical audit cycles. These were 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. We saw three recent examples of these at the practice relating to diabetes medicines and dizziness in the elderly, measuring vitamin B12 levels in patients who are prescribed metformin and the prescribing of certain medicines for patients receiving aspirin or anticoagulant medicines. All had been completed in line with the recognised clinical audit cycle.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. For example one of the practice nurses led on infection prevention and control, and the GPs led on safeguarding. We spoke with a total of eight members of staff and they were all clear about their own roles and responsibilities. They all said they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that practice staff meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings or during the regular informal discussions that took place.

Measures were in place to maintain staff safety and wellbeing. Induction and on going training included safety topics such as the prevention of the spread of potential infections and other health and safety issues. A procedure for chaperoning patients was also in place to protect staff as well as patients.

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

The practice had gathered feedback from patients through the yearly practice patient survey and comments and complaints received. We looked at the results of the January 2015 GP patient survey and the survey conducted by the practice in December 2014. Both surveys reflected high levels of satisfaction with the care, treatment and services provided. However where issues were identified action had been taken to address them.

Are services well-led?

Good 

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

The practice had an active patient participation group (PPG). We spoke with three members of the PPG prior to our visit to the practice. They told us that when issues were identified the PPG was actively consulted to develop plans to address them. They felt their views and contributions were respected and valued. Patients were being encouraged to actively comment on the services available and the planned developments.

The practice had gathered feedback from staff through staff meetings and informal discussions. Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management and that their contributions were respected and valued. 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 regular training and appraisal. We saw that staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff told us that the practice was supportive of them accessing training relevant to their role and personal development.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved.