Irlam Medical Practice 2

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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Irlam Medical Practice. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on 2 October 2014. We spoke with patients, staff and the practice management team.

The practice is rated as Outstanding. An innovative, caring, effective, responsive and well-led service is provided that meets the needs of the population it serves. Our key findings are as follows:

The service is safe. There are systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events are recorded and shared with multi professional agencies and there is evidence that lessons are learned and systems changed so that patient care is improved.

The service is effective. There are systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients. According to data from the Quality and Outcomes Framework (QoF), which is the annual reward and incentive programme detailing GP practice achievement results, outcomes for patients registered with this practice are above average for the locality. Patient care and treatment is considered in line with best practice national guidelines and staff are proactive in promoting good health.

The service is caring. The practice are pro-active in obtaining as much information as possible about their patients including carer status, family dynamics, dependency and any other outside influences which do or can affect their health and wellbeing. All the staff know the practice patients very well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

Summary of findings

The service is responsive. The practice plans its services to meet the diversity of its patients. There are good facilities available, adjustments are made to meet the needs of the patients and there is an appointment system in place which enables good access to the service.

The service is well led. The practice has a clear vision and set of values which are understood by staff and made known to patients. There is a clear leadership structure in place, quality and performance are monitored and risks are identified and managed.

We saw areas of outstanding practice. For example :

- All the practice staff proactively follow up information received about vulnerable patients. We saw five examples where clinical and reception staff had used their initiative when they had raised a concern or passed on information which led to a positive outcome for the patient.
- The practice also reaches out to the local community. The practice nurses voluntarily carry out an annual stroke awareness clinic at a local supermarket for the whole community and have been doing this for the last five years.
- We saw excellent examples of close working partnerships with other health and social care professionals which includes care planning. Care Plans are in place for two per cent of the practice patients as part of a national enhanced service and with a view to avoiding unplanned admissions to hospital.
- Clinical audits are undertaken on a regular basis and results from those audits are used to improve the quality of services provided. An infection control audit checked that patients using nebulisers were educated in routine maintenance of their machines to reduce the risk of bacterial contamination and advice was reinforced during annual reviews of their care.
- Significant events are recorded and shared with multi-professional agencies in and outside the practice. We saw evidence that lessons are learned and systems changed so that patient care is improved.
- There is good leadership and a strong learning culture within all the staff who have a clear vision with quality and safety as their top priority. Staff respond to change and are encouraged to bring suggestions for improvement. We saw a high level of constructive staff engagement and staff satisfaction.

There were areas where the practice should improve. For example

- The practice did not pro-actively obtain and record feedback from patients about minor surgery and did not regularly encourage people to comment about their care and treatment.

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?

Outstanding ☆

The practice was rated as outstanding for safe. There were robust systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who used the service. Patients we spoke with told us they felt safe. Information from the Clinical Commissioning Group (CCG) and the Local Area Team (LAT) indicated that the practice had a good track record for maintaining patient safety. Staff took action to learn from incidents and made appropriate safeguarding referrals when necessary. There were appropriate checks to clarify that staff were suitable to work with vulnerable people. All the staff had been at the practice for a considerable number of years and locum staff were consistent. Significant events were recorded and shared with multi-professionals, including members outside the practice.

Are services effective?

Outstanding ☆

The practice was rated as outstanding for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both NICE and other locally agreed guidelines but we also saw evidence that these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice and its staff were using innovative and pro-active methods to improve patient outcomes and linked with other local providers to share best practice. Consent to treatment was always obtained where required and this was evident when speaking to patients. The practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience who were developed in their role.

Are services caring?

Outstanding ☆

The practice was rated as outstanding for caring. Data showed patients rated the practice higher than others for some aspects of care. Eleven CQC comments cards reviewed and discussion with six patients on the day all provided positive feedback. All said that staff were extremely person-centred and they were always treated with respect and compassion. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them.

Summary of findings

The practice was pro-active in obtaining as much information as possible about their patients including carer status, family dynamics, dependency and any other outside influences which would or could affect their health and wellbeing.

Are services responsive to people's needs?

Outstanding 

The practice was rated outstanding for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice reviewed the needs of their local population and engaged with the Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access and a named GP and continuity of care. Urgent appointments were available the same day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Outstanding 

The practice was rated as outstanding for well-led. There was good leadership and a strong learning culture and the practice had a clear vision which had quality and safety as its top priority. The service effectively responded to change and encouraged its staff to bring suggestions for improvement. There was a clear set of values which were owned and understood by all staff and were evident in their behaviours. The team used their clinical audits, supervisions, knowledge obtained from other sources and staff meetings to assess how well they delivered the service and made improvements where possible. There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued and rewarded for the jobs they undertook and they were encouraged and trained to improve their skill sets. We found there was a high level of constructive staff engagement and a high level of staff satisfaction.

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

Outstanding ☆

The practice was rated as outstanding for the care of older people. Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns. Older patients with known memory or confusion issues were contacted by telephone to remind them of appointments. Home visits for flu vaccinations and health checks were arranged for older people who struggled to attend the surgery. Carer status was regularly checked to ensure their needs and the needs of the patient were being met and practice nurses visited older people if an urgent appointment was required. There were specific clinics for older people's health checks and information on healthy eating and exercise were promoted on the practice website and via leaflets in the surgery waiting room. Caseloads were discussed and altered in order to streamline care for patients at care homes. Each older patient had a named GP. District Nurses and Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

People with long term conditions

Outstanding ☆

The practice was rated as outstanding for the care of people with long term conditions. The practice nurses had voluntarily carried out an annual stroke awareness clinic at a local supermarket for the last five years. At the clinic they provided health and blood pressure checks, signposting and identification of any underlying health issues. Any issues were then referred on to the person's GP regardless of the practice or GP they were registered with. A system had been introduced to maximise checks at a new "first assessment" clinic specifically for people with long term conditions. A recall system had been introduced to identify and combine regular tests which were required by people with long term conditions. A large amount of information was available on the practice website with many links to various supportive organisations. Leaflets were also available at the surgery. The practice worked with Salford Clinical Commissioning Group (CCG) and patients admitted to hospital with COPD and asthma problems were referred directly to the practice nurse who would pro-actively contact them to discuss the nature of their admission and arrange care to minimise any future recurrence. Patients who were part of the unplanned admission national enhanced service and had care plans in place would be contacted by their doctor following any admission.

Summary of findings

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. Staff knew their patient population very well and we saw a system in place to identify children or parents at risk. We also saw an example where a patient at risk had been protected. Children and young people were treated in an age appropriate way and their consent to treatment using appropriate methods was requested. Antenatal, baby immunisation clinics and mother and baby clinics with a nurse and GP were available. Any child due an immunisation or baby check was sent an invitation by the Child Health Department and the practice would also send a text message reminder of the appointment date and time. A pregnancy planner was available with information from inception to birth and beyond.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age patients. A number of clinics and services to promote good health and wellbeing were available for all patients. Emergency appointments, telephone consultations, a later clinic on a Monday and an extra evening clinic from 6.30pm until 8.30pm were available to accommodate people working between the hours of 9am and 5pm. Repeat prescription requests were available in person and on-line and were ready to collect within 48 hours. Exception was made for some patients unable to access these services and reception staff had a list of patient names who had agreed an alternative method of request. A new text appointment reminder system had been introduced. Staff interacted with all people in a respectful and considerate manner and there was a private area for speaking if required.

People whose circumstances may make them vulnerable

Outstanding

The practice was rated as outstanding for the care of people living in vulnerable circumstances. All the staff at the practice, including the receptionists, were pro-active and innovative when following up information received about their patients, specifically those who were vulnerable. The staff knew all the practice patients well and were able to identify a person in crisis. We saw five examples whereby a person in vulnerable circumstances had been identified and saw how staff had intervened to provide help, arranged appointments and worked in close partnership with other health and social care professionals to assist the patient. Intervention had included access to an interpreter, further specialised appointments, domestic abuse information, sexual health advice, and social care assistance. We saw evidence of joint working with families, carers

and the community learning disability team for those patients with learning disabilities. Staff understood about safeguarding vulnerable patients, they had access to the practice policy and procedures and they were appropriately trained.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Staff knew how to recognise and manage referrals of more complex health needs and the practice included other health professionals at their practice meetings when required. People showing signs of dementia or memory problems were given extra assistance if required such as telephone reminders about appointments. Staff were encouraged to be aware and to raise any concerns should a patient appear dishevelled or forgetful. Patients on regular medication were always invited for a medication review before their prescription was repeated. Information was shared with other health and social care professionals and information and signposting was available through the practice website and leaflets in the surgery. A depression questionnaire was also available on the practice website for completion before each appointment so that the GP was aware of any changes since the last visit.

Summary of findings

What people who use the service say

We spoke to six patients who used the service and one member of the newly set up patient participation group. We reviewed comments from 11 CQC comments cards which had been completed.

The patients we spoke to said they were very happy with the service they received. Most people were happy with the appointment system and all knew they could speak to a doctor or a nurse over the phone whenever they needed to. Patients knew they could have someone present at their consultation if required and were able to speak in a private area if necessary. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

Most patients said they weren't pro-actively asked about their opinions until recently but also said they felt able to report any issues to any of the staff and that staff were helpful and went the extra mile. They said staff were like friends and always treated them with dignity and respect.

We were told that the GPs always explained procedures in great detail and were always available for follow up help and advice. They were also aware that they could access their records if required.

The comments cards reviewed were all positive saying the staff go above and beyond, and patients always felt they were always listened to. Reception staff in particular were praised for their helpfulness and the nurses and GPs were praised for their compassion and effective treatment.

A patient participation group was being initiated. This group was a way for patients and the GPs to listen to each other and work together to improve services, promote health and improve the quality of care. Requests for volunteers were advertised through the practice website and within the practice newsletter which was available in reception.

Areas for improvement

Action the service SHOULD take to improve

The practice did not pro-actively obtain and record feedback from patients about minor surgery and did not regularly encourage people to comment about their care and treatment.

Outstanding practice

All the practice staff proactively followed up information received about vulnerable patients. We were shown five examples where clinical and reception staff had used their initiative when they had escalated a concern or passed on information which had led to a positive outcome for the patient. Information available at the time had been as little as a passing comment about a patient in the waiting room, to a concern by a member of staff about a patient who did not speak English.

The practice also reached out to the local community. The practice nurses voluntarily carried out an annual stroke awareness clinic at a local supermarket for the whole community and had been doing this for the last five years. Consultations included blood pressure checks, discussions about flu vaccinations and other general health advice was offered. If concerns were identified or vaccinations required the patient was sent to their GP with a letter regardless of the practice to which they were registered.

We saw excellent examples of close working partnerships with other health and social care professionals which included care planning. Care Plans were in place for two per cent of the practice patients as part of a national enhanced service and with a view to avoiding unplanned admissions to hospital.

Summary of findings

Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. An infection control audit checked that patients using nebulisers were educated in routine maintenance of their machines to reduce the risk of bacterial contamination and advice was reinforced during annual reviews of their care.

Significant events were recorded and shared with multi-professional agencies in and outside the practice. We saw evidence that lessons were learned and systems changed so that patient care was improved.

There was good leadership and a strong learning culture within all the staff who had a clear vision, with quality and safety as their top priority. Staff responded to change and were encouraged to bring suggestions for improvement. We saw a high level of constructive staff engagement and staff satisfaction.

Irlam Medical Practice 2

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**,** a GP expert, a specialist practice manager and an expert by experience. An expert by experience is someone that has used health and social care services.

Background to Irlam Medical Practice 2

Irlam Medical practice delivers primary care under a General Medical Services Contract between themselves and NHS England. As part of the Salford Clinical Commissioning Group (CCG) they are responsible for a population of 3,821 within Irlam, Cadishead and Rixton. The female population is slightly higher than the male at 53% and 16% of the practice population are over the age of 65. The largest population group, 62%, are between the ages of 17 and 65.

Services include access to three partner GPs (one male and two female) who do 17 surgery sessions between Monday and Friday. Extra sessions cater for Mondays which are the busiest day, and other sessions between Monday and Friday include early starts (08.30 Tuesday and Wednesday) and a late finish (20.30 on a Wednesday). These clinic sessions accommodate people outside the hours of 9am and 5pm. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed at the weekends. The doctors are able to carry out minor surgery procedures and provide injections on painful joints.

There is an all-female nursing team of two nurses who work part time and do 13 sessions per week. There is also a part time female health care assistant who carries out a dual role coupled with administration. The nurse clinics promote healthy living, provide support and cater for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

There are clinics for mothers and babies provided by a nurse and one of the doctors and there are well-man, well-women and well-elderly sessions. The premises are shared with local community services such as physiotherapists, district nurses, health visitors, school nurses and podiatry. This enables easier access to those services for the practice's patients in most circumstances and also facilitates communication about patients.

An administration team of four whole time equivalents and a full time practice manager are employed in the running of the practice and were highly praised by all the patients we spoke to.

There were no previous performance issues or concerns about this practice prior to our inspection.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. 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, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Detailed findings

This practice had not been inspected before and that was why they were included as part of the Salford Clinical Commissioning Group.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes 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, we always ask the following five questions of every service and provider:

- 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 were provided for specific groups of people and what good care looked like for them. The population groups were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Salford Clinical Commissioning Group (CCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 2 October 2014. During our inspection we spoke with all the staff available on the day. This included two of the GP partners, a locum GP, two nurses, a health care assistant, the practice manager and four administration staff. We also spoke to six patients who used the service and one member of the newly set up patient participation group. We reviewed comments from 11 CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room, and during some consultations with the permission of the patients.

Outstanding ☆

Are services safe?

Our findings

Safe Track Record

Information from the quality and outcomes framework (QoF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development.

The practice had systems in place to monitor patient safety. Minutes of meetings evidenced that significant events and changes to practice were discussed with all practice staff including the nurses and administration staff if that was deemed appropriate. Action was taken to reduce the risk of recurrence in the future. GPs completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. If it was deemed necessary, events and lessons learned were shared with multi-professional agencies outside the practice.

Administration and reception staff were aware of the significant event analysis policy and knew how to escalate any incidents. Staff were aware of forms that required completion and all staff said they would report any incidents to the practice manager.

We saw an example where staff had reported a passing comment about a patient overheard in the waiting room. This escalation of information had prompted the practice nurse to look into the matter and discuss it with her peers and seniors. This had led to the involvement of other health and social care professionals which promoted a positive outcome for the patient concerned. We saw evidence of this and other discussions such as these recorded in practice meeting minutes.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events.

A recent significant event had been recorded and raised with Salford Royal Infirmary's laboratory to ensure that the relevant health or social care professionals were made aware of the details.

Multi-disciplinary practice meetings took place where attendance included clinicians from other disciplines such as Macmillan Nurses, safeguarding leads, community midwives or health visitors. Minutes from the meetings identified sharing information and reflective practice to reduce risk and improve services going forward.

Significant events that we reviewed showed the date the event was discussed, a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. We saw evidence that changes in practice had been applied. For example we saw that new forms had been introduced to record natural deaths for end of life patients and a system created to ensure that abnormal blood results were reviewed in their entirety. We were shown how these changes to clinical practice had reduced the risk of the event recurring in the future.

An audit in March 2014 ascertained if patients using their own nebulisers had been educated in routine maintenance of their machines to reduce the risk of bacterial contamination. Evaluation included discussion within the practice and an action to reinforce advice during annual reviews with patients suffering from chronic obstructive pulmonary disease (COPD).

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults were up to date and staff knew where to locate them. There was also access to Salford City Councils policies and procedures and a matrix for escalation with contact names and numbers for each different safeguarding incident.

One of the partners was the safeguarding lead for the practice and attended safeguarding lead meetings hosted by the Clinical Commissioning Group (CCG). All clinicians had completed adult safeguarding and child safeguarding to level 3 and were updated on a three yearly basis. The lead had completed mental capacity and deprivation of liberty safeguards training as well as lessons learnt and child sexual exploitation training. They had also attended a domestic violence training session in September 2014 as had one of the other GPs and both of the practice nurses.

Minutes of a safeguarding meeting held 11 September 2014 included discussion about changes to local multi agency safeguarding services and deprivation of liberty safeguards and training. This showed us that the practice kept up to date with current safeguarding information. A service for

vulnerable young adults was highlighted and patients within the practice were discussed to see if any might be eligible. We saw an example where a patient had been deemed appropriate for this service and was referred. This showed that a specific vulnerable group were considered for opportunities that may be beneficial to their health.

Staff were trained to undertake chaperoning procedures as per the practice policy. Details about chaperone facilities were seen in the waiting room and consultation/treatment rooms. We observed patients being offered the use of a chaperone where appropriate.

Chaperone training for staff had been done over two years ago. The GPs agreed that training for all staff would be reviewed to make sure they understood what was required, such as being able to identify if a patient felt uncomfortable in any way and how to identify and report any issues that may be witnessed.

The chaperone policy was also part of a locum checklist so that locums were aware of the procedure within the practice.

Medicines Management

We saw that medicines management was on the agenda of a partners' meeting in September 2014 as part of the CCG Incentive Scheme 2014/15. Clinical audits for sore throats, urinary tract infections and atrial fibrillation (AF) were discussed and it was noted that AF patients were already being reviewed following changes in guidelines. We saw that audits were carried out by the CCG Medicines Management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available within each clinic and treatment room. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. There was a clear policy for maintenance of the cold chain with actions to be taken in the event of any potential failure. No controlled drugs were kept on site.

The practice had a protocol for repeat prescribing which was in line with GMC guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. There was a system for reviewing patient's repeat medicines to ensure it was still safe and necessary. Only four members of staff were able to prescribe medicines and this included the GP partners and one of the nurses.

Cleanliness & Infection Control

Infection Prevention and Control (IPC) was of utmost importance within the practice and the IPC policy was very explicit. It interacted with other policies and procedures such as the service level agreement for cleaning staff and guidance for hand washing. Both clinical and non-clinical staff had specific IPC responsibilities clearly identified within the policy. These included cleanliness and maintenance of sterile and non-sterile appliances and areas within the building.

The senior nurse and one of the GP partners with overall lead for IPC had attended training provided by Public Health England on 4th December 2013 and all other staff had completed Blue Stream on-line training. Blue Stream Academy are providers of eLearning/online training for GP practices helping to ensure Care Quality Commission (CQC) compliance.

Occupational health was commissioned by Salford CCG and pre-employment medical checks and Hepatitis B immunisation checks and updates were carried out every five years. The practice were informed of the results and a copy was kept on staff personnel files.

We observed the premises to be clean and tidy and saw that facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in all the patient toilets and in all the treatment rooms.

The IPC audit carried out by the CCG in 2013 had identified areas for improvement and these had been actioned. The audit completed on 24 September 2014 evidenced 100 per cent compliance. The lead nurse carried out reflective practice as part of the multi-disciplinary team (MDT) agenda and discussed improvements with staff and what they could do next to maintain these excellent standards.

Legionella testing was not part of the routine annual service carried out on the air conditioning system and was not required. A service of the air conditioning was due to be carried out on 17 October 2014.

Outstanding ☆

Are services safe?

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing and calibration of equipment such as spirometers to measure lung capacity and nebulisers used to help breathing. These were maintained to International Organisation Standardisation (ISO) guidelines.

Emergency drugs were stored in locked drawers within each treatment room and vaccines were appropriately stored in fridges specific for that purpose. The fridge temperatures were checked twice daily and we saw logs to ensure that these were within acceptable limits. A log of maintenance was in place and a record noted when faults were identified and parts required replacement or repair.

We saw evidence that portable appliance testing had been undertaken and was up to date and calibration of equipment had been carried out where necessary. The air conditioning system had been serviced on 10 July 2013 and was due for re-service in October 2014.

Staffing & Recruitment

The provider recruitment policy was in place and up to date. Appropriate pre-employment checks were completed for a successful applicant before they could start work in the service. All the GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses and phlebotomist also had criminal records bureau (CRB) checks undertaken and copies of those were kept in their files. Staff were asked to produce copies of their eligibility to work in the UK. The staff at the practice had all been employed for several years and there was little or no staff turnover. The staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence.

The practice GPs covered each other's absence as much as possible and a locum agency was not used. When locum cover was required GPs who were known to the practice were used and patients reported continuity even when referring to locum GPs.

Monitoring Safety & Responding to Risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. We saw that staff had specific areas of responsibility but no one person was responsible in entirety. This in itself reduced the risk of error.

There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the practice manager if an accident occurred. They knew where to record the information and to share what could be done with other staff to reduce the risk of it happening again. All events and incidents were discussed at staff meetings and staff told us that reflection and learning was seen as a normal part of the day.

The practice had recently introduced a role whereby administration staff were responsible for recall appointments. "Recalls" were when a patient required an appointment to check a variety of health related issues for their long term conditions. The new system combined all the checks for a patient into one appointment therefore reducing the risk of missed appointments or checks being delayed.

Arrangements to deal with emergencies and major incidents

Basic life support training was done every year with all staff and clinical staff undertook training in anaphylaxis.

We spoke with staff who had been trained and knew what to do in the event of an emergency such as sudden illness or fire. We saw emergency equipment and emergency drugs which were available and up to date and staff knew where these could be located. There were panic buttons in all consulting rooms and according to a member of staff they were able to respond to emergencies "within seconds" because of their close proximity.

The practice manager was responsible for managing expected and unexpected absences which could cause disruption to the running of the practice. Staff were multi-skilled and were able to quickly cover each other's roles in the event of emergency absence. Most of the staff at the practice had been employed for many years and knew the patients well. Staff we spoke to told us they were able to identify if patients were unwell, agitated or distressed and could take them to a private room if necessary whilst they waited for assistance.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients spoken with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and cardiovascular and other regular health checks and screenings were ongoing in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, eye disease, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach.

Care plans had been put in place for two percent of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of national enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate. Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included work in conjunction with the Royal College identifying and reflecting on new cancer patients identified. A nebuliser audit identified areas where GPs could provide advice to patients on the maintenance of their equipment thereby reducing failure and decontamination. An audit on infection control identified areas for improvement which led to the practice achieving 100 per cent in this area when they were re-audited this year.

We saw evaluations of medication for people with heart problems or asthma where treatment was changed if required so that the best outcomes could be achieved. We saw that where changes in treatment were offered, and sometimes refused, the patient was given information by the practice about the benefits or otherwise and were therefore enabled to make an informed decision.

The practice reviewed patients under a national enhanced service to minimise admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

Regular clinical meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with a hospital consultant about treatment for long term conditions that resulted in a positive outcome for the patient concerned.

Effective staffing

All the staff at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff were multi-skilled and able to carry out the role of their colleagues.

All the staff were long serving but there was an induction process for any new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

Two of the doctors had been revalidated and one was due for revalidation in January 2014. Nurse professional registrations were up to date and appraisals were carried out annually on all staff although we did observe that the practice manager had not yet been appraised this year.

All patients we spoke with were complimentary about the staff and we observed staff who appeared extremely competent, comfortable and knowledgeable about the role they undertook. There was enough staff to meet the demands of the practice although we observed that the GPs worked over and above their sessional agreements. If this became unsustainable then another clinician may be required at some point in the future.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services who shared the building and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced

that district and palliative nurses attended the GP quality team meeting to discuss the palliative patients registered with the practice. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice had access to Salford Royal Hospital's integrated record service and this enabled review and management of blood results, discharge letters and other notifications. We also saw how the practice spoke and worked collaboratively with other hospitals and consultants to the benefit of its patients. An arrangement was in place whereby patients admitted to hospital with COPD and asthma problems were referred directly to the practice nurse who would pro-actively contact them to discuss the nature of their admission and arrange care to minimise any future recurrence. Patients who were part of the unplanned admission national enhanced service and had care plans in place would be contacted by their GP.

Systems were being implemented whereby hospital letters and discharge documents would be directed and reviewed by the named GP for each patient. The partners had agreed the best way to achieve this and this was being implemented by administration staff. Telephone messages about specific patients were always passed to the named GP for that patient as were home visit requests. This encouraged continuity of care for the patient. Where this was not possible, the telephone message was triaged by the doctor-on-call to decide whether the patient could wait for a routine visit or required a more urgent visit by someone else.

Information Sharing

GPs met regularly with the practice nurses and administration staff. Information about risks and significant events was shared openly and honestly at practice meetings. There were three partners and all attended community lead discussions such as safeguarding, domestic violence, and neighbourhood meetings. The lead GP attended CCG meetings and discussed what they had learned in practice meetings. This kept all staff up to date with current information around enhanced services, requirements in the community and local families or children at risk.

Patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend practice meetings. The GPs and the practice manager attended local community meetings. Feedback from community meetings was shared with practice staff where appropriate.

There was a practice website with information for patients including signposting, services available and latest news. There was also a monthly patient newsletter and information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more private information.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

GPs and clinicians were Mental Capacity Act trained and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

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

A parent/patient told us they had been able to accompany their vulnerable young adult child to an appointment where treatment had been explained in detail. This had reassured both the patient and their parent as both understood the process.

Health Promotion & Prevention

All new patients were offered a consultation and health check with one of the practice nurses. This included discussions about their environment, family life, carer status, mental health and physical as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. The phlebotomist/health care assistant held follow up clinics to promote healthy living and provided advice on smoking cessation, diet and alcohol intake.

First assessment care plans had been introduced for new patients identified with diabetes. Advice on management

Outstanding ☆

Are services effective?

(for example, treatment is effective)

and control of their condition was provided and a "passport of information" was given to the patient to take with them on their visits to the nurse. This encouraged the patient to take ownership and overall responsibility for their wellbeing.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle.

The practice also reached out to the local community to promote better health. A community stroke awareness clinic had been set up voluntarily by the practice nurses who attended a local shopping centre on an annual basis. Consultations included blood pressure checks and discussions about flu vaccinations and other general health advice was offered. If concerns were identified or vaccinations required the patient was sent to their GP with a letter regardless of the practice to which they were registered. The nurses we spoke with advised that patients who had not visited the practice for some time had been identified during this process and appointments offered to them if required. Nurses from another practice had been encouraged to take part in this initiative and assist in the promotion of wellbeing for all people in the community.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt more than just well cared for and that staff were very considerate, friendly and genuinely concerned and attentive to their needs. We were able to observe clinical practice with the consent of the patients and we saw that the doctors showed empathy and were respectful throughout the consultation. Privacy during consultations was maintained; curtains were used to hide modesty and window blinds were closed. Conversations could not be heard through closed doors. Patients spoke highly of the practice, the reception staff and the doctors. One patient went out of their way to tell us about the wonderful care they had received at the practice that day and every time they visited.

Reception staff were respectful and patient. We saw two people who requested to speak to someone in private and they were able to do so easily. There was a genuine and friendly connection between the reception staff and patients of all ages. Patient experience feedback showed a high degree of satisfaction with the service provided and the attitude towards them by the staff who delivered it. Patients described the practice as "the family doctor" and indeed most of those we spoke with told us that all their families, children and grandchildren, used the same practice.

A patients' charter which outlined the service the patient could expect was "upheld" according to patients we spoke with. The practice induction described medical ethics in detail and all staff had completed e-learning around dignity and respect.

Care planning and involvement in decisions about care and treatment

The practice proactively worked in close partnership with other health and social care professionals. Patients were encouraged to take responsibility for their conditions and to be involved in decisions about medication and other forms of treatment. We saw examples of integrated care and care planning which generated significant positive impact for the patients concerned. The practice were undertaking care planning as part of a national enhanced service and all had been completed. To do this the GPs had visited a lot of the patients in their own homes and had carried out the planning with the involvement of the patient's family, friends or carers. Patients we spoke with told us they were always asked for their consent before any procedure or treatment was undertaken. We were also told there was ample opportunity to discuss any health concerns and one patient told us that they were "never rushed" during consultations. Older patients with known memory or confusion issues were contacted by telephone a day before their appointment as a reminder.

All the staff we spoke to were effective in communication and all knew how to access and use Language Line if required and described an incident when this had been required. Language Line is a worldwide telephone interpretation service. Literature was available in different languages if and when required. We saw that patients' information was treated with the utmost confidentiality and that information was shared appropriately when necessary using the correct data sharing methods.

We looked at the consent policy and talked to clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements. Clinical staff had been Mental Capacity Act 2005 trained and other staff were aware of the term "mental capacity" and had completed e-learning.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that all the staff were able to provide emotional support. Nurses described incidences when they had gone over and above expectation to support a person with their treatment. We saw evidence where "passing comments" had led to patients receiving care that they may not otherwise have received but for the diligence of all the staff from reception to practice clinicians and further involvement of other health or social care professionals.

We looked at ten CQC comments cards that had been completed and spoke to 8 patients. All comments were positive. Comments stated that they were pleased with the service, were treated with respect and said that the GPs went above and beyond what was required to make sure the care offered was appropriate. Patients we spoke to said they always had enough time to discuss their problems and could make longer appointments if they needed them. There was information on what to do in times of bereavement and patients we spoke with told us they were supported through all emotional circumstances. 91% of

Outstanding ☆

Are services caring?

patients who responded to the most recent GP survey said that the GPs treated them with care and concern. The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. Full details of the practice results are available on the internet.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

All the practice staff pro-actively followed up information received about vulnerable patients.

We were shown five examples where clinical and reception staff had used their initiative when they had escalated a concern or passed on information which had led to a positive outcome for the patient. Information available at the time had been as little as a passing comment about a patient in the waiting room, to a concern by a member of staff about a patient who did not speak English. We saw how clinicians had made impromptu home visits in their own time, identified safeguarding issues, helped people to get home safely and liaised with other health and social care professionals. Multi-disciplinary meetings had been arranged and ways to help and support the patients concerned had been discussed at length. These impromptu interventions had clearly made a considerable positive impact to the patients' health and wellbeing.

The lead GP and the practice manager attended neighbourhood meetings together with the CCG and received feedback and information from those meetings. In August 2014 they received information about Healthier Together which is promoting a change to healthcare in Greater Manchester. Information about this change was displayed in the waiting room and questionnaires were available for completion and return to NHS England. However the practice was not pro-actively promoting completion and were not aware if the forms were being sent off.

The practice responded to feedback, if any, on other sites such as their Facebook page and NHS choices. They also had plans to contact people by email if agreed and patients could leave comments on the practice website. The web sites were good for people who were computer literate but not those who preferred to use pen and paper. We saw that people were able to feedback verbally and their comments were responded to, but did not see evidence that this was routinely recorded.

Tackling inequity and promoting equality

The premises were shared with another practice and community services. Initially it was unclear to us where patients should sit because the waiting room was also shared. None of the patients spoken with found this to be an issue and the staff said that new patients were clearly instructed about the layout. There had been instances where patients had waited in the wrong place and missed the screen which announced their appointment, but in those cases the GPs had come to reception to make sure the patient had arrived and had not left before being seen.

The seats in the waiting area were basic and all of one height and size. There was no variation for diversity in physical health and none of the chairs had arms on them to aid sitting or rising. The practice premises did not belong to the GPs themselves and the landlord was responsible for variations to the building. However, the GPs were able to make changes to the fittings and fixtures if they chose to.

Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues and described a time where they had used an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Access at the front of the surgery was good with automatic doors to the entrance and a back door entrance for wheelchair users. There were also seats by the back door where patients could rest on their way in if necessary.

There was a good appointment system where people could receive same day emergency appointments, telephone consultations with their named GP whenever possible, call backs, and home visits by the doctors. The nurses also

went on home visits as an interim, following a discussion, if the doctor could not manage. Caseloads were discussed and altered in order to maintain consistency for patients at a particular care home.

We saw that the practice did respond to feedback where they were able. For example wheelchair users mentioned that a kerb outside was causing difficulty to access and egress of the building and this was now being addressed following discussion with the landlord. There was adequate car parking available on the premises and in the street.

A Patient Participation Group had recently advertised for members and five patients had agreed to be part of the group so far. They had not yet held a meeting and terms of reference were still to be set up. However the practice were looking forward to receiving feedback from the group to see what could be done to improve the service for their patients.

Listening and learning from concerns & complaints

We saw clear evidence that this was a practice with a leadership and learning culture. There was a clear understanding which included learning from significant events and partnerships with other agencies. There was a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated person responsible for handling complaints in the practice. If a complaint was about this person then it was dealt with by the lead GP and we saw evidence of this.

We reviewed some complaints received and saw that they were dealt with in line with the practice policy. We saw that most complaints were brought to a conclusion which was satisfactory to the patient. One case had taken some time to resolve but every effort had been made by several staff including the GPs to bring the matter to a satisfactory resolution. This was eventually achieved with the complainant still attending the practice and still seeing the same GP.

We saw minutes from staff meetings which showed that all complaints were discussed and reflected upon. It was evident that if changes could be made to improve outcomes for the patients then this was done.

We saw that compliments were also received regularly. We looked at thank you cards and letters of appreciation praising the staff and the care and treatment received.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

Discussions and evidence we reviewed identified that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

The practice leaflet and website stated that the practice were interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved. The staff were dedicated to providing a service with patient's needs at the heart of everything they did.

GPs and the practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly. They worked with local safeguarding, domestic violence and young people's organisations to make sure they were aware of the requirements within their patient population.

Governance Arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. Each topic had a practice lead and reception and administration staff were included in areas of responsibility such as monitoring appointments and introducing systems to improve the smooth running of the practice. All staff we spoke with were aware of each other's responsibilities and who to approach to feedback or request information. Those systems and feedback from staff showed us that strong governance structures were in place.

The practice manager took an active role for overseeing the systems in place to ensure they were consistent and effective. The GP partners were also pro-active in that process. The practice manager was also responsible for ensuring that policies and procedures were kept up to date and that staff received training appropriate to their role. There was evidence that feedback from patients was discussed with all staff and learning was applied.

Leadership, openness and transparency

All staff were observed to follow the vision and values of the practice which were very clear. There was an open and honest culture and clinical, administrative and reception staff all encompassed the key concepts of compassion, dignity, respect and equality. They welcomed input from patients of the practice and acted upon feedback. Staff understood their roles and were clear about the boundaries of their abilities.

Staff felt supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries. Individual responsibilities were given to each member of staff and opportunities for progression were apparent. Staff felt valued and were rewarded for the good work they provided.

The practice manager undertook appraisals for the reception, administration and nursing staff on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Doctors received appraisal and two of the GPs had been revalidated through the revalidation process. The other had a date for revalidation in January 2015. The practice manager had not yet received their annual appraisal which was undertaken by the lead GP.

Practice seeks and acts on feedback from users, public and staff

There was a distinct air of openness within the practice, between all staff members and between patients and staff. Patients spoken with reported that they felt comfortable providing concerns, compliments or complaints to all members of staff and in particular to the practice manager. Information received was acted upon and we saw evidence that changes were made to working practice where ever possible.

A Patient Participation Group was in its initial stages and the practice were looking forward to receiving information they could use to consider improvements to the service for their patients.

Management led through learning & improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction as did any locum staff. Learning objectives for

Are services well-led?

Outstanding ☆

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

existing staff were discussed during appraisal and mandatory training was role relevant. E-Learning was carried out and one member of staff showed us how they could access information on the internet to improve their knowledge. A core set of training was provided by the local area team for all staff and this was monitored on an annual basis with all staff requiring update or renewal at the same time.

Nurses and GPs kept their continuing personal development up to date and attended other courses pertinent to their roles and responsibilities within the practice such as domestic violence, infection control, medicines or minor surgery procedures. This ensured that patients received treatment which was most current.