Brooklands Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brooklands Medical Practice on 23 July 2015. Overall the practice is rated as good.

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

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients feedback on accessing appointments with GPs and nurses was positive.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

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

Importantly the provider should:

- Implement a formal process for minuting meetings.
- Complete an infection control audit and ensure all staff receive infection control training or updates as required.
- Put in place a formal business continuity plan

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated via team meetings 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes for 2013/14 were average for the locality, these were not a true reflection due to a computer upgrade. Data overtime showed the practice to be above average. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans being in place for staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reports were positive in relation to accessing appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had clear aims to deliver good outcomes for patients. Staff

Summary of findings

were clear about the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients. Staff had received inductions, attended staff meetings and had access to annual appraisals.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice had 348 people aged 75 and over, which represented 6.1% of the practice population. This was slightly higher than the CCG average (5.5% in 2014). Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework.

The practice was responsive to the needs of older people, meeting fortnightly with district nurses to enhance communication regarding patients with complex needs.

The practice had achieved 81% vaccination rate for the influenza vaccine for those over 65.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. A third of patients (1927 – 34%) aged 18-74 had at least one long-term condition; many had several, all had a named GP. Recognising that many patients have multiple morbidities, the doctors review many of these patients on a regular basis, allowing for a holistic approach to the patients' care and avoiding multiple visits for patients to the practice.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice had an electronic register of patients with long term conditions and a recall system in place to ensure patients were called for annual review so their condition could be monitored.

The national Quality Outcome Framework (QOF) 2013/14 showed that the majority of clinical and public health outcomes had been achieved to the same level or just below the local CCG and national average. For example 100% of outcomes for patients with asthma and 99% of outcomes for patients with Chronic obstructive pulmonary disease (COPD) had been achieved. We noted however for conditions such as diabetes the practice was below the local and national average, which the practice were addressing. It should be

noted the data for 2013/14 was not an accurate reflection of the practice overtime, but in the main due to problems with a computer upgrade. Data overtime showed the practice to be above average in majority of outcomes.

Patients at high risk of emergency admission had care plans in place and were contacted regularly. Patients at high risk had same day access to a GP to avoid emergency admission into hospital.

Patients with COPD or asthma were provided with personalised management plans to help in the event of exacerbation.

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care. Fortnightly meetings are held with the Macmillan nurse to enhance communication and continuity of care for patients with cancer or those receiving palliative care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up vulnerable families who were at risk.

Telephone contact was made with all post-natal patients once notification of discharge was received, and visited if necessary. This was followed up with a 'new baby pack' being sent to patients. The practice offered a 'one stop shop' which incorporated a post-natal check and developmental checks for their new baby. At the same time the practice nurse also administered the initial childhood vaccinations. Immunisation rates were high for all standard childhood immunisations. Where children and babies failed to attend for immunisations these would be followed up by the practice nurse.

Appointments were available outside of school hours for children and all of the staff were responsive to parents' concerns and would ensure parents could have same day appointments or telephone consultations for children who were unwell.

The practice provided access to contraceptive advice and treatment, with easy access to a female doctor when required. The practice offered a contraceptive coil and implant fitting service.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of the working-age people (including those recently retired and students). The practice offered

online services as well as a full range of health promotion and screening which reflected the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation and weight management.

Patients were able to access appointments outside of normal working hours with appointments available Tuesday or Wednesday evenings and from 7:00am Friday mornings.

Appointments and prescriptions could be booked online in advance. Telephone consultations were also available to patients who could not attend the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities with a named GP and offered longer appointments for people when required. For patients where English was their second language, an interpreter could be arranged. The practice referred homeless patients to the specialist GP practice in the local area.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review with a named GP. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Links had been established with a psychiatrist from the local hospital enabling the GPs to seek guidance and at times carry out joint consultations with patients.

Any patient who was at risk of dementia had been identified by the practice and screening was carried out opportunistically. The practice had a high rate of identifying dementia and where required care plans were in place. The practice had good links with psychiatrists specialising in older people from whom they could seek guidance on patient care and treatment.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with 13 patients. We reviewed 31 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2014/15 and noted 96% described their overall experience of this surgery as good and 97% had confidence and trust in the last GP they saw or spoke to.

We saw in the six months from December 2014 to May 2015 from the friends and family test, 91% selected extremely likely that they recommend the GP practice to friends & family if they needed similar care or treatment.

Areas for improvement

Action the service SHOULD take to improve
Implement a formal process for minuting meetings.

Complete an infection control audit and ensure all staff receives infection control training or updates as required.

Put in place a formal business continuity plan

Brooklands Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice manager and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Brooklands Medical Practice

Brooklands Medical Practice provides primary medical services in Wythenshawe, Manchester, from Monday to Friday. The practice is open between 8.00am and 6.00pm Monday to Friday, closed Thursday afternoon. The practice operate extended hours, on alternate Tuesdays 6.30pm – 8.00pm, alternate Wednesdays 6.30pm – 8.00pm and Fridays 7am - 8am.

Brooklands Medical Practice is situated within the geographical area of NHS South Manchester Clinical Commissioning Group (CCG).

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Brooklands Medical Practice is responsible for providing care to 5659 patients of whom 50% were male and 50% were female, with 10% black and minority ethnic (BME) patients.

The practice consists of five GPs, four female and one male, a nurse practitioner, practice nurse and health care assistant. The practice was supported by a new practice manager, receptionists and secretaries.

Brooklands Medical Practice is a training practice, accredited by the North Western Deanery of Postgraduate Medical Education and has two GP specialist trainees (GPST).

When the practice is closed patients were directed to the out of hour's service GoToDoc.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

Detailed findings

We carried out an announced visit on the 23 July 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with 13 patients and seven members of staff. We spoke with a range of staff, including the GPs, practice manager, nurse practitioner, health care assistant and reception staff.

We reviewed 31Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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)

Good

Are services safe?

Our findings

Safe Track Record

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

We reviewed safety records, incident reports and spoke with staff who confirmed incidents were routinely discussed. This showed the practice had managed these consistently over time and demonstrated a safe track record over the long term.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, We saw from the practice significant events records and speaking with staff that investigations had been carried. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via meetings and emails. The nurses told us they received regular updates as part of their ongoing training. They also undertook self-directed learning and attended learning events.

Reliable safety systems and processes including safeguarding

The staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection, vulnerable adult's and domestic violence policy and procedure. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead and they had completed adult and children's safeguarding training. All other staff had completed safeguarding training and provided evidence and examples of having a clear understanding of their safeguarding responsibilities.

Chaperones were available for patients with notices informing patients of their rights to ask for a chaperone within the waiting area and clinic rooms.

Medicines Management

The practice held medicines on site for use in an emergency or for administering during consultations such as administering of vaccinations.

The nurse practitioner was qualified as an independent prescriber and received weekly mentoring and supervision from a GP providing support within their role as well as updates in the specific clinical areas of expertise for which they prescribed. The nurse and nurse practitioner administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse and advanced practitioner had received appropriate training to administer vaccines.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

The practice worked alongside the CCG medicines management team who supported the practice to look at prescribing within the practice and audit medicines such as antibiotics and benzodiazepines to support the practice to ensure they are following up to date prescribing guidance.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals, such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

Good

Are services safe?

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was seen to be clean and tidy. A nurse had recently taken the lead for infection control. There had been no audit of infection control carried out by the practice in recent years, however arrangements had been made with the local CCG infection control team to carry out an audit and update training with staff where required during 2015.

Contract cleaners were employed by the practice who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis and the practice held a copy. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly.

We saw the dignity curtains in each room were disposable and labelled showing when they required replacing.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single patient use instruments and we saw these were stored correctly and stock rotation was in place.

Equipment

The practice ensured all equipment was effectively maintained in line with manufacturer's guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

A panic alarm system was in place in consulting rooms and behind reception for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of four staff including the most recently recruited staff. We saw for staff recently recruited checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health had been carried out. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks to ensure that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. All health and safety information was available to practice staff via the internal computer system.

The practice had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and stored securely in the reception area. We checked the emergency drug box and saw that medicines were in date. We found a defibrillator and oxygen were available for use in an emergency. All staff knew the location of this equipment and records confirmed that it was checked regularly.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains. This included guidance from the Resuscitation Council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

An informal business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice and staff were aware of who to contact. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. We were told a formal written plan was to be developed by the new practice manager to cover all identified risks as a priority.

We saw a fire risk assessment that included actions required to maintain fire safety had been carried out following the building renovations.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, nurse practitioner and health care assistant we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines.

The GPs, nurse practitioner and health care assistant we spoke with explained how they reviewed patients with chronic diseases such as asthma on an annual basis. The national Quality Outcome Framework (QOF) 2013/14 showed that the majority of clinical and public health outcomes had been achieved to the same level or just below the local CCG and national average. (It should be noted the data for 2013/14 was not an accurate reflection of the practice overtime, but in the main due to problems with a computer upgrade. Data overtime showed the practice to be above average in majority of outcomes). For example 100% of outcomes for patients with asthma and 99% of outcomes for patients with Chronic obstructive pulmonary disease (COPD) had been achieved. We noted however for conditions such as diabetes, dementia and hypertension the practice were below the local and national average.

Data from QOF 2013/14 showed the practice achieved 78% of outcomes for patients with diabetes, 10% below the local CCG average and 12% below the national average. Speaking with GPs they informed us of lost data following a change to IT systems which reflected in the lower than average outcomes for 2013/14 and they demonstrated they were working towards improving these outcomes following an improved IT system and call, re-call system. The practice also introduced a named GP approach for patients with long term health conditions. Data for 2014/15 showed a significant improvement in outcomes for patients with diabetes. We also saw the practice had made significant improvements to the outcomes for patients with dementia with 32% increase in the number of patients whose care has been reviewed in a face-to-face review in the preceding 12 months

We saw the practice maintained a register of patients with a learning disability with named GPs taking a lead role in reviewing their care and treatment on an annual basis. We were provided with a range of examples of support provided to patients with learning disabilities including the HCA supporting a patient daily with stockings to prevent blood clots, culminating in the purchase of a support tool to enable the patient to self manage their own care.

GPs carried out annual physical health reviews for patients diagnosed with mental health needs, including those with schizophrenia, bi-polar and psychosis, as a way of monitoring their physical health and providing health improvement guidance. The practice provided data from QOF for 2014/15 showing the practice was responding to the needs of people with poor mental health, with outcomes the same or above the average for the local CCG. For example 91% had a comprehensive care plan documented in the record and patients had access to health checks as required, such as a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurses told us they received regular updates as part of their ongoing training.

Clinical staff were able to describe to us how they assessed patients capacity to consent in line with the Mental Capacity Act (MCA) 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. A pathway was in place as part of the cancer improvement scheme to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held fortnightly with other health and social

Good

Are services effective?

(for example, treatment is effective)

care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet patients physical and emotional needs and ensured that whenever possible patients die in the place of their choosing.

We were told for patients where English was their second language an interpreter could be booked in advance or accessed via the telephone. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic Obstructive Pulmonary Disease (COPD).

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments. The nurse practitioner provided a range of examples of patient information leaflets they provided to patients to self-manage conditions such as COPD and Asthma.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patients outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We were shown a number of audits such as Atrial fibrillation screening in practice and gestational diabetes.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 94% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Patients told us they were happy with the way doctors and nurses at the practice managed their conditions and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. With a new practice manager one week into post at the time of our inspection. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support and safeguarding. We noted a good skill mix among the GPs and nurses with a number having additional training and qualifications for example the nurse practitioner held diplomas in respiratory diseases such as asthma and COPD and the practice nurse held a diploma in diabetes management. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Speaking with staff and reviewing records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively. The practice had an appraisal system in place for all staff.

The nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example on administration of vaccines, cervical cytology and treating minor ailments.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they received updates and new guidance during team meetings. We saw the GPs and nurses had access to training as part of their professional development, attending training and education events in which updates on key issues were provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Multi-disciplinary meetings were arranged with other health and social care providers where required and communication took place on a daily basis with community midwives, health visitors and district nurses by telephone and fax.

The practice worked with other service providers to meet patients needs and to manage patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge

Good

Are services effective?

(for example, treatment is effective)

summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

Patients were able to access support and treatment through an alcohol worker from the community alcohol team at the practice on a weekly basis.

GPs at the practice were able to access an on call consultant to support them in the care and treatment of patients with poor mental health.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice sent referrals directly to a central referral unit and those referrals such as two week wait referrals were sent electronically. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The GPs described how the practice provided the 'out of hours' service with information to support, for example, 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were seen and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC which was shared with local care services and out of hour providers.

Consent to care and treatment

A detailed policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, recording consent, consent from under 16's and consent for immunisations; however there was no reference to support patients who do not have capacity to consent in line with the Mental Capacity Act 2005.

Speaking with staff they were clear about their responsibility to gain and where required record consent. We found staff were aware of the Mental Capacity Act 2005, the Children's' Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). We saw from significant event analysis the practice had used the principles of the Mental Capacity act to provide care and treatment in the best interest of a patient.

All clinical staff we spoke with made reference to Gillick competency when assessing whether young people under 16 were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. Where capacity to consent was unclear staff would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

The practice had a range of written information for patients in the waiting area which could be taken away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. During discussions with GPs and nurses it was clear they were aware of supporting patients physical, emotional and social needs to enable healthy lifestyles.

Good

Are services effective?

(for example, treatment is effective)

The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The nurses and health care assistant provided lifestyle advice to patients this included dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. The nurses actively referred patients to community services and healthy lifestyle programmes such as Physical Activity Referral Service (PARS).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 74% vaccination rate for the influenza vaccine for children and adults at risk.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella. We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake was 82%, above the local average.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, details were passed onto the named GP and where any follow up was required staff would arrange an appointment or home visit.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with 13 patients and reviewed 31 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out process if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was away from the reception desk to maintain privacy.

We observed staff speaking to patients with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in a private area.

Patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 89% of respondents found the receptionists at this surgery helpful above the local CCG and national average.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones and modesty sheets to maintain patients dignity.

We found all rooms had dignity screens and lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

Patients told us they were happy to see any GP or nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey, showed 97% had confidence and trust in the last GP they saw or spoke to and 100% had confidence and trust in the last nurse they saw or spoke to, both above the local and national average.

The practice operated a named GP system for those patients with complex care needs, this enabled continuity of care and wherever possible, home visits and on the day appointments patients would be seen or contacted by the named GP. We saw from the GP national survey 79% of respondents with a preferred GP usually get to see or speak to that GP, 21% above the local and 19% above the national average.

We saw from The Quality and Outcomes framework (QOF) data for 2014/15, 91% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. This was above the local and national average.

The practice had formal care plans in place developed by named GPs for patients and they included care plans for vulnerable patients over 75 year of age, patients with poor mental health and those patients at risk of unplanned hospital admissions. Where consent had been obtained from patients the care plans were shared with the neighbourhood team consisting of a range of health and social care providers to ensure co-ordinated care.

We noted where required patients were provided with extended appointments. For example reviews with patients with learning disabilities, those who required an interpreter or had multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke with were articulate in expressing the importance of good patient care and also had an understanding of the emotional needs as well as physical needs of patients and relatives.

Good

Are services caring?

From the GP national survey 96% of respondents stated the last GP they saw or spoke with was good at listening to them, 96% say the last GP they saw or spoke with was good at giving them enough time and 96% said the last nurse they saw or spoke with was good at giving them enough time. These figures were all above the local and national averages.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice worked with patients and families and also worked collaboratively with other providers in providing palliative care and ensuring patients wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as opportunistic screening and reviews, accommodating home visits, accommodating early morning and evening appointments for working age people, booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients via the website and a box at reception or requesting repeat prescriptions with staff at the reception desk. The practice had recently introduced electronic prescribing and we observed reception staff promoting this service to patients when they came into the practice to collect prescriptions. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice did not have a patient participation group. We were told patients were open with practice staff and any issues/concerns or suggestion patients were able to speak directly with the practice manager or GP, poster encouraging feedback were displayed across the practice. Other methods of gathering feedback included the friends and family test.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example longer appointment times were available for patients with learning disabilities or those who required an interpreter.

The practice was able to book face to face translators for Non-English speaking staff in advance of appointments or access interpreters over the telephone if required.

The practice was accessible for patients with disabilities. A disabled toilet was available as were baby changing and breast feeding facilities.

There were male and female GPs in the practice therefore patients could choose to see a male or female doctor.

GPs and nurses were flexible in offering appointments to people outside of core hours. Extended hours were available on alternate Tuesday and Wednesday evenings and Friday mornings.

Access to the service

The practice was open between 8.00am and 6.00pm Monday to Friday and closed Thursday afternoon. The practice operate extended hours, on alternate Tuesdays 6.30pm – 8.00pm, alternate Wednesdays 6.30pm – 8.00pm and Fridays 7am - 8am. All appointments for GPs and nurses could be booked by patients either in person, on the telephone or online.

A range of face-to-face appointments, telephone consultations and home visits, both on the day and for up to three months in advance were available for patients to book. The practice held a proportion of the appointments for on-the-day appointments and they operated an on-the-day emergency appointment system where patients were contacted or seen by either a GP or nurse practitioner. Where ever possible the practice aimed to maintain continuity of care with a named GP or nurse seeing or contacting patients even with on-the-day emergency appointments. We were provided with examples of positive outcomes of this continuity of care especially with patients with poor mental health. We noted the practice placed alerts on vulnerable patients electronic records which alerted reception staff to offer patients, for example those at risk of unplanned hospital admissions, same day appointments.

Patients views on the appointment system were all positive. We saw from the GP national survey 92% of respondents described their experience of making an appointment as good and 94% were able to get an appointment to see or speak to someone the last time they tried; 23% above the CCG average and 19% above the national average.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to patients about appointments on the practice website. This included information about the appointment system and home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed and this information was detailed on the practice website. If patients called the practice when it was closed an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented. Lessons learned were shared with staff at team meetings.

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so. Reception staff told us they would give patients the option of speaking with the practice manager or a GP at the time for any verbal complaints or issues they felt could be resolved informally.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients and we saw this displayed within the practice. We found details of the vision and practice values were part of the practice statement of purpose, for example, 'Our overall aim to provide high-quality, patient-centred, accessible primary health care.' We saw this demonstrated in the way staff interacted with patients and how they spoke of the professional relationship developed with patients over a number of years.

We spoke with nine members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. A review of all practice policies and procedures was to be carried out by the new practice manager to ensure they were all in place and up to date. We looked at several of the policies and saw these reflected current guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. We were told the practice had recently introduced new partnership meetings in which they would clearly record actions, outcomes and decisions, after it was acknowledged they did not have a clear system in place for minuting meetings.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG) and General Practice Outcome Standards (GPOS) to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF 2013/14 data for this practice showed it was an average performing practice compared with other local practice in the CCG area. The practice were aware of the data, we were told this was due to a range of factors including loss of data following changes to their IT system.

Data overtime showed the practice were above average for majority of outcomes. In 2012/13 98% of all outcomes were achieved and in 2014/15 92% of outcomes had been achieved, confirming the data for 2013/14 was atypical. We also noted in the first six months of 2015/16 the practice had already reached 72% of outcomes.

The GPs and nurses met informally on a daily basis to discuss patient care and seek advice and guidance from colleagues. The new practice manager and GPs met regularly as part of the practice manager's induction to discuss practice issues, practice development and to look at a formal structure for staff meetings. The nurse practitioner had formal meetings with a GP mentor on a weekly basis to discuss clinical updates and patient care. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place. The GPs within the practice conducted individual clinical audits, in which outcomes were shared to monitor quality and share learning.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of maintenance and equipment checks which had been carried out in the past twelve months by the practice. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager. Staff told us there was never a time when there was no one available to seek support, advice or guidance. Speaking with the advanced nurse practitioner they told us whenever they required support during a consultation GPs were available and a secure IT system was in place to allow the nurse to message GPs regarding patient care and seek guidance.

The new practice manager was responsible for human resource policies and procedures. We reviewed a number

Are services well-led?

Good

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

of policies and procedures. For example a recruitment policy and induction programme was in place to support staff. We were shown evidence that staff, as part of induction, had access to policies and procedures. All staff were able to access policies and procedure via the policies and procedure electronic file, which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies and new members of staff confirmed they formed part of the induction process.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented with lessons learnt shared with staff.

We reviewed the results of the GP national survey carried out in 2014/15 and noted 96% described their overall experience of the practice as good and 95% would recommend this surgery to someone new to the area, 19% above the CCG average and 17% above the national average and placed the practice in the top 5% of practices nationally. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to provide feedback on the services). We saw in the six months from December 2014 to May 2015, 91% selected extremely likely that they recommend the GP practice to friends & family if they needed similar care or treatment.

There was no patient participation group at the practice, but this was an area the new practice manager would be looking at during 2015/16.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and development opportunities and appraisals up to date for staff.

Speaking with one GP trainee at the practice they were complimentary of the learning opportunities and the practice and the support and supervision they had received.

The practice had reviewed significant events and other incidents and shared with staff informally.

Two GPs lectured at universities for example one GP was a Senior Lecturer in Medical Education at Keele University Medical School, another was Associate Hospital Dean for Primary Care at UHSM (Wythenshawe Hospital) and an examiner for the Royal College of General Practitioners.