Marple Cottage Surgery

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?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Summary of this inspection — Page

Letter from the Chief Inspector of General Practice 2

The six population groups and what we found 4

Detailed findings from this inspection

Our inspection team 5

Background to Marple Cottage Surgery 5

Detailed findings 7

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall. (Previous inspection February 2016 the practice was rated Outstanding)

The key questions are rated as:

Are services safe? – Outstanding

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those retired and students – Outstanding

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Marple Cottage Surgery on 22 February 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

At this inspection we found:

- The established strong leadership at the practice had a clear vision, which put working with patients to ensure high quality care and treatment as its top priority. There was a commitment by all the practice staff to deliver a quality service.
- The practice implemented a comprehensive strategy with supporting business plans that reflected their vision and values. A cycle of continuous quality improvement that incorporated all aspects of practice activity was implemented and aligned with the practice Strategy and Improvement Plan. This helped it to understand risks and gave a clear, accurate, and up to date picture that led to safety improvements.
- There was an individual and team ethos of commitment to deliver the highest quality services to patients. The whole practice team fostered a culture of 'can do' with patient care and customer satisfaction central to everything it did.
- The culture of the practice was to deliver a person-centred care and treatment service to all its patients. Its objectives emphasised the partnership approach between the practice and patients. This

relationship was based on mutual respect and active involvement of patients in their own care by increasing education, promoting self-care and providing support with encouragement to lead healthier lives.

- The practice had been committed for many years to providing patients with full online access to their medical records. Feedback from patients identified this had helped them understand their health condition better.
- Following participation in the trialling of integrated video consultations, the practice now offered a video consultation service to patients. These appointments had been successfully used by patients whilst at work and for undertaking some long term condition reviews.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. The practice had an inclusive approach to this and each member of the staff team had responsibility for implementing systematic checks to ensure patients received safe and timely care. A ‘Red Flag’ policy was accessible to all staff from their desktop computer whereby specific health care symptoms were triggers for staff to take immediate action.
- The GPs provided care and treatment to a range of community and residential services. These include providing end of life care to a community based ward, daily support to a specialised community ward for patients with delirium and weekly visits to a residential care home and a nursing home for patients with dementia.
- The practice implemented an annual training strategy. The practice had agreed with the staff team core goals and principles for 2018 and this provided a structure for regular planned training, staff meetings, and individual support.
- The training and development of trainee GPs and medical students was also structured. For example, trainee GPs were responsible (with support and supervision) for visiting all housebound patients biannually, to monitor healthcare needs and to undertake long term condition reviews.

We saw several areas of outstanding practice:

- The practice had a communication strategy, which was underpinned by its culture of providing patient-centred customer care. The practice trained its staff in customer care, used a communication protocol to respond positively and supportively to all customer/ patient requests, and used feedback from patients/ customers to improve on how the staff team communicated with people.
- The practice had recognised the anxiety and distress caused to families, designated next of kin and carers of patients accommodated in residential and nursing dementia care homes. To support these family members and carers the practice offered half hour appointments to discuss their relative’s health and treatment plan. These meeting also provided the opportunity for participants to agree the patient’s care plan including what actions should be taken in the event of deterioration in the patient’s health.
- The practice continued to be proactive in identifying Good Service Examples where staff had responded to the individual needs of a patient to ensure they received the right care and support. These Good Service Examples were logged and used as a learning and development aid for the staff.
- The practice peer reviewed all secondary care referrals. All GPs including locum GPs had to request a peer review of every secondary care referral they proposed to make. Systems were effectively established so that all referral were logged and reviewed by another GP within a two to three hour timescale.
- The practice facilitated and supported its patients and the local population to provide health education meetings. The Chief Clinical Officer from Stockport Clinical Commission Group provided the most recent patient education event “Stockport Together”. The practice invited patients from other GP surgeries in the Marple area. Seventy people attended. The practice had arranged a follow up meeting in March 2018 to allow the Stockport Together team to answer questions on how the initiative would affect Marple.

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

Summary of findings

The six population groups and what we found

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

Population group	Rating
Older people	Outstanding ☆
People with long term conditions	Outstanding ☆
Families, children and young people	Outstanding ☆
Working age people (including those recently retired and students)	Outstanding ☆
People whose circumstances may make them vulnerable	Outstanding ☆
People experiencing poor mental health (including people with dementia)	Outstanding ☆

Marple Cottage Surgery

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 adviser.

Background to Marple Cottage Surgery

Marple Cottage Surgery is located at 50 Church Street, Marple, Stockport, SK6 6BW. The GP practice is part of the NHS Stockport Clinical Commissioning Group (CCG). The practice provides services under a Personal Medical Services contract with NHS England and has 7139 patients on their register. More information about the practice is available on their website address: www.marplecottage.co.uk

Information published by Public Health England rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male and female life expectancy in the practice geographical area broadly reflects the CCG and England averages for both males (79 years) and females (82 years).

Patient numbers in the older age groups are higher than the CCG and England averages. For example data from Public Health England for 2016/17 shows that 24% of the patient population is over the age of 65 years, 11% are over the age of 75 years and 2.9% are over 85 years. The CCG averages are 19%, 9% and 2.6% respectively and the England averages are 17%, 8% and 2.3% respectively.

The practice has 58% of its population with a long-standing health condition, which is slightly higher than the CCG average of 55% and the England average of 54%. Unemployment at 5% reflects the national average but is slightly higher than the local average of 3%.

The practice has one male non-clinical partner and two male GP partners. The practice employs two female salaried GPs, one nurse practitioner, one practice nurse, one healthcare assistant, two reception supervisors, seven reception and administrative staff and one informatics manager. The informatics manager was the lead person for ensuring the internal standards of information management were adhered to.

The practice is a teaching practice accepting undergraduate medical students and a training practice for qualified doctors who are training to be a GP. Both GP partners are trainers.

The practice telephone lines are available from 8am and the surgery is open from 8.15am each weekday. The practice closes at 6.30pm on Tuesdays and Wednesdays and at 6pm on Fridays. Extended opening is available until 8pm on Mondays and Thursdays and between 8.30 am and 10.30am one Saturday each month. On Tuesdays, the practice is closed between 12.30 and 1.30pm for staff training. Medical cover is provided by the Out of Hours service during this period.

Patients are asked to contact NHS 111 for Out of Hours services.

The practice provides online patient access that allows patients access to their full medical record, to book appointments and to order prescriptions. The practice also provides on their website the email addresses of the GPs, practice nursing team and practice manager. This allows patients to communicate directly with a clinician or manager of their choice, if they have a query or a question.

Detailed findings

Marple Cottage Surgery provides services from a large late Victorian detached property. There are ten consultations rooms, seven of which are available on the ground floor. If a patient is unable to access the first floor then arrangements are in place to see patients on the ground floor. The practice building has been adapted to provide access for people with disabilities.

Outstanding

Are services safe?

Our findings

We rated the practice, and all of the population groups, outstanding for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had a comprehensive annual strategy and improvement plan that underpinned the practice's commitment to ensure safe systems and processes were established and implemented. The strategy and improvement plan was supported with a project management tool that scheduled a monthly timeline (Gantt chart) of tasks to be undertaken. A breakdown and allocation of monthly tasks that included clinical audits to be undertaken / re-audited, and review of protocols and policies supplemented this.
- All staff had access to safety information including policies and procedures from their desktop computers. These were reviewed and updated regularly, at least annually and in response to changing guidance.
- The practice delegated lead roles to staff members both to ensure effective management of safety issues and as a development tool to broaden staff member's skills and abilities. For example one of the administrative staff members was the operational supervisor who ensured the implementation of a comprehensive range of safety risk assessments, including those for fire, Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), building safety checks and general health and safety issues. The practice's extensive range of safety policies were easily accessible to all staff, were regularly reviewed and staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly, who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. GPs and the nurse clinician were all trained to level 3 in children's safeguarding, had received training in female genital mutilation (FGM) and Prevent training (raising awareness to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves).
- The practice team worked with other agencies to support and protect patients from abuse, neglect, discrimination and breaches of their dignity and respect. The GP lead for safeguarding had worked hard to establish regular contact with the health visitor. This enabled the practice to monitor more effectively the children identified on their safeguarding register. Safeguarding was a standing meeting agenda item and discussed at the practice's weekly clinical meetings.
- The practice monitored children who missed healthcare appointments, and contact was made with the parents or carer to discuss the reasons for not attending.
- Children who had attended accident & emergency on a regular basis were followed up by the practice to identify any potential safeguarding concerns.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones were trained for the role and had received a DBS check. The practice had a policy in place that reception and administrative staff did not undertake this role. All administrative and reception staff spoken with had a clear understanding that they were not to be alone with patients at any time.
- The practice maintained appropriate standards of cleanliness and hygiene. The local authority health protection nurse had undertaken an infection control audit at the practice in December 2015 and December 2017. The practice scored 100% across all areas including: Management, Clinical Practices, Clinical Areas, Domestic Store and Waste Management at both these audits. The nurse practitioner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. In addition to the

local authority infection control audit, the practice carried out their own annual infection control audit programme, which included monthly checks and a random handwashing audit.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems in place to support the safe management of healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Clinicians had clear leadership roles and responsibilities. Administrative and reception team members worked to a comprehensive rota, which detailed the day-to-day priorities and allocated roles with specific tasks to each staff member. A back up staff member was also allocated. This was effective in maintaining service and minimising risks to patients when unforeseen circumstances occurred.
- The practice preferred not to use temporary staff but in the previous 12 months, circumstances had required their use. This had enabled the practice to review and improve their induction training so that temporary staff were clear about the standards of care and service required of them and how they could access support in achieving this.
- Patient safety was a priority and the practice's desk top front page had a visible link to the practice's 'Red Flag' policy, whereby specific health care symptoms were triggers for reception staff to take immediate action including interrupting a GP consultation if the patient was on the telephone. Clinicians knew how to identify and manage patients with severe infections, including sepsis. Appropriate policies and protocols were available. The practice provided two recent examples (September and December 2017) where they had implemented their sepsis protocol, which resulted in rapid assessment and treatment at the local hospital.
- Since our previous inspection, the practice had installed a defibrillator. The availability of the defibrillator ensured the practice could respond more effectively in the event of a cardiac arrest. All staff received annual basic life support training, including using the defibrillator.
- The practice had emergency medicines available in the treatment room including oxygen with adult and children's masks. A first aid kit and accident book were available.
- Following discussion at the practice's patient forum (patient participation group) external lighting had been installed in the practice car park and additional lighting was being fitted to the external pathways to improve patient and staff safety.
- Following two recent potentially violent incidents, the practice had installed a wireless alarm system directly linked to the police. This was supported by a 'raising an alarm' policy and was implemented to protect patients and staff.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The practice was committed to involving patients in understanding and managing their health conditions. The practice had been committed for many years in providing patients with full online access to their medical records and we heard of examples whereby patients had challenged GPs on the completeness of the discussions undertaken between patient and GPs.
- The electronic patient information system allowed the staff team access to patient information as required. The system flagged up the specific needs of patients so staff could respond appropriately to patient queries. The practice had developed a range of self management and care plan templates that they completed with patients and these detailed patients' wishes for example for those requiring end of life care. Copies were provided to patients. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way and this included the Out of Hours service (OOHs).
- Monthly multidisciplinary team meetings were held to discuss those patients considered at high risk. District nurses and Macmillan nurses attended these meetings.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The practice had liaised with the local hospital trusts regarding how they could send electronical referral letters safely to them. The hospital had agreed that the proforma of information they required could be sent

electronically by the practice. The practice developed electronic letter templates for each GP that reflected the hospital trusts' proforma of required information. Systems of monitoring included a weekly audit and a quality assurance check to ensure patient referral information was delivered safely and quickly.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use. Processes were in place for handling repeat prescriptions, which included the review of high-risk medicines.
- The practice had a comprehensive safe process to ensure any patients prescribed high-risk medicines were closely monitored. There was a system of regular checks and searches of the patient care record system to review that necessary monitoring was up to date and adhered to guidance.
- The practice worked closely with the clinical commissioning group (CCG) medicine optimisation team. The practice had a staff member who was the practice based medicines coordinator who with the support of the medicine optimisation team carried out regular medicine audits, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The nurse practitioner was a qualified non-medical prescriber and could therefore prescribe medicines for specific clinical conditions. They maintained their skills and knowledge and obtained support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines against a patient specific direction from a prescriber. Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- The practice reviewed and audited their antimicrobial prescribing every fourth month. There was a risk benefit assessment in place to monitor ill patients to avoid unnecessary prescribing of antibiotics.
- We viewed a number of medicine related clinical audits including those on the use of antibiotics for urinary tract infection (Trimethoprim and Nitrofurantoin). The outcome of this audit showed the practice was performing better than the England average.
- Another clinical audit compared two types of anticoagulants, medicines used to treat and prevent blood clots. The audits considered a number of factors including the reasons for treatment, who initiated treatment (for example secondary care), patient involvement and preference and the cost.
- The practice responded quickly to NICE updates, for example, the practice was reviewing all patients who were diagnosed with chronic kidney disease (CKD) and the advice to prescribe statin medicine.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. A five year annual premises maintenance programme was in place alongside an annual risk assessment schedule, an annual premises improvement plan and annual review of the disaster recovery and business continuity plan. A continuous quality assurance cycle was implemented to ensure a safe and effective service was provided.
- As part of the quality improvement/assurance cycle all aspects of practice activity were monitored and reviewed. This helped to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The practice had an ethos of "no blame but openness; learn rather than defend". Staff we spoke with felt confident to raise concerns.

Outstanding

Are services safe?

- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice. These were discussed at practice meetings and learning was shared with staff and more widely where appropriate.
- The practice also identified good service examples where staff had gone that 'extra mile' to assist or support a patient. These examples were also discussed and practice meetings and used to inform the practice's communication and customer service policy.
- There was a system for receiving and acting on safety alerts. The practice was responsive to patient safety alerts; for example, the practice had posted an alert on their Social Media Internet page at the time they received the alert, advising patients that some well-known asthma inhalers were being recalled, as they did not deliver the correct dose of medicine.

Outstanding

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, outstanding for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The practice implemented a planned programme of regular review and update of all clinical protocols and procedures taking into account updated guidance from NICE and patient safety alerts. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance, and we saw that this was used to inform the practice's clinical audit programme. We saw no evidence of discrimination when making care and treatment decisions.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. One of the practice's objectives was to work with patients in partnership to actively involve them in the management of their care. To support the practice in achieving this they had developed a range of electronic care and self-management plans to use with patients. This included a record of their clinical needs and their mental and physical wellbeing. We saw several examples of individualised care plans for patients who were housebound, those identified at high risk of admission to hospital, those with a long term conditions, and those living within residential and nursing home settings. The care and self-management plans provided patients with guidance on what action to take if their condition deteriorated. Staff also provided advice as required.
- Prescribing data for the practice showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group for the period 01 July 2016 to 30 June 2017 was comparable to other local GP practices. (This data is used nationally to analyse practice prescribing and 'hypnotics' are drugs primarily used to induce sleep).
- Similarly, data for the prescribing of antibacterial prescription items showed that practice prescribing was slightly lower (0.80) when compared to local and national levels (1.04 and 0.98 respectively).
- Data for the percentage of antibiotic items such as Co-Amoxiclav, Cephalosporins or Quinolones for the period 01 July 2016 to 30 June 2017 showed the practice had a lower rate of prescribing at 2.3% compared to the local average of 5.5% and national average of 8.9%. (Co-Amoxiclav, Cephalosporins or Quinolones are broad-spectrum antibiotics that can be used when others have failed. It is important that they be used sparingly, to avoid drug-resistant bacteria developing).
- At our previous inspection, the practice was trialling the use of video consultations with patients. Since that inspection, the software had improved and the practice had purchased the software and this allowed them to offer video consultations with patients. The video consultations were only undertaken with the agreement and consent of the patient and required the patient to download an application. The consultation was integrated with the patient electronic record and was encrypted. We saw evidence that this software provided a safe environment for patient consultations to occur. The practice had undertaken an electronic patient poll on the video consultations undertaken between January and December 2017. The poll had a 45% response rate; 100% of respondents found it easy to use, 60% used it whilst at work and, 90% would use the service again. The poll identified areas for improving the service and an action plan was implemented.
- The practice implemented a strict system of peer review for all secondary care referrals. All GPs including locum GPs had to request a peer review of every secondary care referral they proposed to make. Systems were effectively established so that all referrals were logged and reviewed by another GP within a two to three hour timescale. The GPs explained that this had proved very useful in generating clinical discussion and supporting learning and development. It utilised the individual clinical expertise of the GPs and identified if the patients' needs could be managed more appropriately at a primary care level. The practice monitored all referrals and these were reviewed at the weekly clinical meeting. In addition, the practice audited the referral and the peer review process on a monthly and annual basis. For example, in 2017 the total number of secondary care referrals made was 581. A total of 39 (6.7%) of these were deflected and 542 were forwarded

onto secondary care. Patients were advised of the peer review referral process and were contacted and advised if the referral was deferred and an alternative treatment strategy was discussed and agreed.

- The practice had been proactive for many years promoting their online service to patient and this included full access to medical records. In addition, the GPs, the nurse practitioner and the practice manager provided their email addresses on the practice website for patients to use. Patients used this service to seek advice or raise minor queries. GPs confirmed that they received approximately five emails a day from patients about various issues and concerns. The practice's criteria was that these were responded to within 24 hours. We saw examples of these to both the GPs and the nurse practitioner. For example, one patient stated they had had a reoccurrence or flare up of a condition and asked if they should recommence treatment, they had previously been prescribed. The practice received 345 emails for the 12 months in 2017. The analysis of the emails identified almost 20% of users of the service were in the age range of 45 to 54 years of age. Almost 13% of emails were received from young people under the age of 16 years.
- The practice had introduced a strategy to improve the patient recall process. This used a process of delayed appointment reminders (DAR) in agreement with the patient to be sent before the next review date. The DAR alerted staff to the upcoming review and a reminder by text and or email was sent to the patient requesting them to arrange a review appointment at a time convenient for them.
- The practice contacted all patients the day before their appointment, if their appointment was 20 minutes or longer, to ensure they were attending.

Older people:

This population group was rated outstanding because:

- The practice recognised their patient population was ageing and implemented a range of strategies to provide proactive support and care to this population group.
- As part of the practice's chronic disease management strategy a register of all patients living at home who were housebound was maintained. There were 39 patients on the register at the time of our visit. The practice implemented a planned programme of twice yearly home visits to all housebound patients. A trainee GP, with GP support and mentoring, undertook these visits. The purpose of the visits enabled a proactive review of the patients' health and wellbeing, a review of their long term health conditions and to provide the trainee GP with learning and development experience. The regular monitoring visits ensured that other health and social care issues were identified and responded to quickly.
- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. The practice encouraged patients to attend a falls prevention and bone health service, 'Steady in Stockport', where a bone and falls risk assessment of the patient was undertaken. The service forwarded the assessment results onto the GP practice. The practice then contacted the patient dependent on the outcome of the assessment and agreed a care and treatment plan and strategy to support the patient. The practice had 309 patients assessed with a moderate frailty and 95 patients with severe frailty. The practice had 124 patients with a diagnosis of osteoporosis. The most recent available Quality and Outcomes (QOF) data from 2016/17 showed 100% of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, were treated with an appropriate bone-sparing agent. This compared favorably with the local average of 76% and national average of 80%. The practice's exception rate was 0% compared with the local and nation rate of 14%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)
- Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services and supported by an individualised and agreed care plan. The practice provided data that showed 93% of patients over the age of 75 (including those assessed as frail) had received a review of their healthcare needs within the last 12 months.
- Data supplied by the practice showed that 87% of patients over the age of 65 years received an influenza vaccination in 2017/18.

Outstanding

Are services effective?

(for example, treatment is effective)

- The practice also provided care and support to older patients living in a residential care home, to 103 patients living in extra care housing and had the highest population in Stockport in receipt of care packages. Close working relationships were established with community health and care team members including social workers, carers and district nursing teams. Patients considered at risk of unplanned admission to hospital and those discharged from hospital were monitored and supported with self-management care plans.
- The practice worked with Stockport Together (a partnership of health care and social care organisations in Stockport to provide joined up services) and in 2017 they provided general medical services to a 'Community Transfer Unit' where patients were transferred from hospital with a programme of re-enablement to promote and assist patients back into the community.

People with long-term conditions:

This population group was rated outstanding because:

- Systems were in place to ensure all patients requiring a review of their long term condition received a comprehensive review that incorporated all areas requiring review and this included medication reviews.
- The practice implemented a structured leadership strategy for each clinical domain. For example, one GP was the lead for diabetes and they were supported by the nurse practitioner and member of the administration team. This ensured patients benefited from twice yearly monitoring and review.
- Longer appointments and home visits were available when needed. All housebound patients with a long-term condition (including younger patients) were visited regularly to ensure the appropriate screening was undertaken. All these patients also had a self-management or an advanced care plan in place.
- The practice nurse and health care assistant were trained in anticoagulant management and held clinics to monitor patients' blood to determine the correct dose of anti-coagulant medicine. Comprehensive policies and protocols were in place. They also maintained the INR Star registers used for monitoring anti-coagulant medicines, and contacted any patients who were overdue a test or did not attend their scheduled appointment. The nurses worked closely with other health care professionals to ensure patients who required surgical procedures were closely monitored and treated to ensure the optimum anti-coagulation therapy was provided both pre and post operatively.
- All these patients had a named GP and a structured twice-yearly review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Data supplied by the practice showed that 80% of patients under the age of 65 years and considered at risk received of influenza received a vaccination in 2017/18.
- The practice supported patients with diabetes and the nurse practitioner was trained in insulin initiation. One of the GPs was undertaking additional training to develop further the practices' diabetes strategy and plans were in place to implement monitoring and support for patients assessed as pre-diabetic. Blood measurements for diabetic patients (HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 87% of patients had well controlled a blood sugar level which was higher than the clinical commissioning group (CCG) average of 82% and national average of 80%.
- QOF data available for other long-term conditions showed the practice performed well when compared to local and national averages. For example:
- The percentage of patients with hypertension (high blood pressure) in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 90%, compared to the CCG average of 85% and the national average of 83%. Exception reporting at 5% was comparable with local averages of 3% and national averages of 5%.
- The percentage of patients with COPD (Chronic Obstructive Pulmonary Disease) patients who had been reviewed in the preceding 12 months was 92%, which reflected the local average of 91% and national average of 90%. Exception reporting was lower at 5% (6% locally and 11% nationally).
- 95% of patients with asthma on the register had an asthma review in the preceding 12 months compared to the CCG average of 78% and the national average of 76%. Exception reporting was much lower at less than 1% compared with 3% locally and 8% nationally. The practice had organised video consultation and review with 25% of its asthma patients.

Outstanding

Are services effective?

(for example, treatment is effective)

Families, children and young people:

This population group was rated outstanding because:

- All babies up to the age of six months of age were seen automatically on the day of request. The practice also implemented a same day access policy for all children and young people.
- The practice had undertaken an audit of the outcome following appointments for acutely ill children from between January 2017 and January 2018. The audit reviewed 511 appointments for children aged 0-16 years and identified 61% (354) patients did not require a prescription, a follow up procedure or referral; 32% were advised to take over the counter medicines and 29% did not require treatment with medicine; 24% of patients required a prescription, and 10 % were prescribed antibiotics.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Data for childhood immunisation rates for the vaccinations given in 2017/18, supplied by the practice demonstrated the practice achieved at a minimum 97% each quarter and just under 98% for the year. The practice supplied immunisation data for each year from 2012 and this showed the practice consistently achieved over 97% annually.
- Data supplied by the practice showed that 86% of two year and three year old patients received an influenza vaccination in 2017/18.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice offered a contraceptive service and pre and antenatal care working closely with midwives who carried out a weekly clinic.
- The practice had a local enhanced agreement with the CCG to provide an in-house vasectomy service to both the practice's patients and patients registered within the Stockport CCG area. At our last inspection in February 2016, the practice planned to implement audit requesting feedback from patients to identify any complications 12 months after the procedure. At this inspection, we saw that this audit had been undertaken and was ongoing.

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

This population group was rated outstanding because:

- Public health data for 2016/17 showed the practice's uptake for cervical screening was 82%, which was higher than the local average of 76% and the national average of 72%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 35-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated outstanding because:

- The practice had a comprehensive palliative and end of life strategy in place and this was supported with clinical protocols.
- The practice team worked with the palliative care team, including Macmillan nurses, the district nursing team, and social care workers to ensure patients died with dignity in a place of their choosing. This had increased the numbers of patients dying at home from 30% to over 80%. They ensured appropriate care plans that included the patient's wishes about where they wanted to die and gave information to carer's in the event of deterioration. Both GP partners visited patients nearing end of life daily as required.
- The practice held monthly multidisciplinary team meetings where vulnerable or at risk patients were identified including those newly diagnosed with cancer, recently bereaved and those without appropriate carer support.
- The practice also provided dedicated general medical services to a specialist unit in Stockport (The Meadows) providing end of life care and community healthcare assessments. In addition, the practice was leading a pilot project using this ward as a transfer for assessment ward.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Data supplied by the practice showed that 95% of patient with a learning disability had an annual review.

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

Outstanding

Are services effective?

(for example, treatment is effective)

This population group was rated outstanding because:

- The practice provided general medical services to a ‘step down ward’ for patients with delirium. The designated GP led the clinical team on the ward and visited daily Monday to Friday. They worked closely with nurses, social workers and psychiatrists, chairing multidisciplinary team meetings. The practice confirmed that 80% of these patients eventually returned home.
- One GP was the lead for a large nursing home providing care to patients with mental health issues including dementia. They provided weekly visits, worked with staff and carers to develop and agree advanced care plans.
- 86% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was comparable to the local average (86%) and higher than the national average (84%). Exception reporting was slightly lower at 4% compared with 5% and 7% respectively.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher than the local rate of 93% and the national rate of 90%. Exception reporting was lower at 6% for the practice, 8% locally, and 12.5% nationally.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 96%; CCG 92%; national 91% with exception reporting 4%, 7% and 10% respectively).

Monitoring care and treatment

The practice had a well-established comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had an annual clinical audit plan, which was underpinned by their annual Strategy and Improvement Plan and Clinical Strategy. The clinical audit plan identified the audits /re-audits and the clinical protocols that needed reviewing for the coming year month by month and showed when these had been completed. These were linked to national guidelines such as NICE. The practice’s clinical strategy actively involved medical students and trainee GP doctors to undertake research and carry out the clinical audits to demonstrate practice quality improvement and to educate and develop the clinical auditing skills of the auditor.

The practice provided many examples of clinical audit covering a wide range of topics including, Osteoporosis (Bisphosphonates), audits on the types of blood thinning medicines prescribed for patients, audits on the prescribing of treatments for urinary tract infection and hypertension. The practice worked closely with the CCG pharmacy team and one staff member was the practice-based medicines coordinator and ensured that practice prescribing was carried out in line with local and national recommended guidelines.

The practice had an Informatics Manager who led the administrative team. Their areas of responsibility included ensuring the internal standards of information management were adhered to. This included indexing, coding, summarising, claims and data management, monitoring and recall. They had devised a comprehensive workflow system with delegated lead roles to different members of the administrative team. Regular one to one meetings were held with the members of the administrative to team to review achievements and to provide support and development. The comprehensive monitoring and review system ensured an accurate and effective recall system for management of long-term conditions and the maintenance of accurate and up to date patient records. The practice had a standard operating procedure to support its quality standard of indexing and work 'flowing' all correspondence within one working day. An audit undertaken between July and December 2017 showed the practice manged it’s work flow efficiently and effectively even in times of unexpected staff absence. The audit showed that 98% of documents overall were work-flowed to a GP on the same day they were received.

The most recent published QOF results (2016/17) were 100% of the total number of points available compared with the CCG average of 98%% and national average of 95%. The overall exception reporting rate was 9% and compared with a national average of 10%. The practice had consistently achieved 100% of the points available since 2010. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice had lower exception reporting when compared with local and national averages for the majority

of the QOF indicators. They had identified, however, that they had higher exception reporting for two of the diabetic indicators. The lead nurse practitioner had undertaken a review and audit of the diabetes exception coding. The review included reference to the updated NICE guidance from 2017 which referred to an individualised approach to each patient considering lifestyle, age and frailty The analysis of patients excepted from the QOF indicator for HbA1c of 64 mmol/mol and cholesterol control identified clearly why patients had been excepted. These included age, dementia, maximum treatment, self-management, contraindication and patient refusal.

The practice had also reviewed its strategy for the management of diabetes and was implementing a plan to improve this service, which included additional GP training and introducing a pre-diabetes screening and support strategy.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- A comprehensive induction programme was in place for undergraduate medical students and trainee GPs. A structured training programme suitable to the stage of education and professional development of the medical students and trainee GPs supported this. Both GP partners were practice trainers and provided mentorship and clinical supervision.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. The nurse practitioner was a nurse prescriber and was trained in insulin initiation. The practice nurse and healthcare assistant were trained in monitoring anti-coagulation therapies and treating patients accordingly. Regular audit of blood results and calibration of equipment was undertaken and closely monitored by the nurses and GPs.
- The practice had a hierarchy of leadership and interviews with staff in senior positions told us how they supported and developed newer members of the team. The practice's annual Strategy and Improvement Plan and Clinical Strategy underpinned the practice's annual training strategy, which detailed quarterly training objectives. The practice had agreed with the staff team Core Goals and Principles for 2018 and this provided a structure for regular planned training, staff meetings and individual support. The learning needs of staff were aligned with the practice's training strategy and core goals and the individual training needs of each staff member.
- Staff received training that included safeguarding, fire procedures, and basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The GPs supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and walking for health.

Outstanding

Are services effective?

(for example, treatment is effective)

- The practice's percentage of new cancer cases referred using the two week wait referral route reflected both local and national data at 50%. Almost 88% of patients had a review within six months of diagnosis, which was 9% higher than the local average and 17% higher than the national average. The practice also had a much lower rate of exception reporting at 13% compared with the local average of 18% and the national average of 25%.
- The practice referred its patients to attend national screening programmes for bowel and breast cancer screening. The practice patient uptake of these tests was similar to the CCG and national average. For example, data from 2016/17 showed that 68% of females aged between 50 and 70 years of age were screened for breast cancer in the last 36 months reflecting the CCG average of 69% and the England average of 70%. Data showed screening for bowel cancer within 6 months of invitation was higher at the practice with a rate of 66% compared to 56% for the CCG and 54% for the England averages.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. Self-management care plans were in place for many patients.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- A health promotion strategy for 2018 was in place and this linked with the NHS England planned health and wellbeing promotions for the year. Planned health promotions included No Smoking day, Ovarian cancer awareness, Prostrate cancer awareness and Bowel cancer screening awareness. The practice planned to use their online social media accounts to target the patient audience.
- The practice had an active patient forum (patient participation group) who worked with the practice to facilitate patient education evenings. Recent education events included one about dementia and more recently, the Clinical Officer from Stockport CCG presented a talk about the Stockport Together programme and how it affected the practice and the local community.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. The practice provided GP care to range of residential and nursing care services for patients with mental health problems including dementia. The GPs were knowledgeable about the Mental Capacity Act, best interest decision making and the Deprivation of Liberty Safeguards (DoLS).
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, good for caring.

Kindness, respect and compassion

The practice leaders fostered a caring culture by treating their staff with kindness, respect and compassion. They believed staff emulated this caring approach when supporting patients and other users of their service.

The practice staff team were able to tell us of many examples of how they treated patients with kindness, respect and compassion. These included responding to people who had suffered a bereavement, recognising when someone was not their usual self and going the extra mile to provide additional assistance with, for example, medicine or prescription problems.

- Staff understood patients' personal, cultural, social and religious needs. All staff had trained in understanding equality and diversity.
- Alternative means of communication were available to patients such as text, email and video consultation. Translation services and extended appointment times were offered and the practice had facilities for patients with a hearing loss.
- The practice gave patients timely support and information. For example, the practice had introduced a strategy to support and reassure relatives or carers of patients living in residential and nursing care homes. The practice offered the patient's carer/relatives half hour appointments to discuss the patient's physical and mental health care and treatment needs. This provided carers/relatives opportunities to discuss the different aspects of treatments and to agree caring approaches and strategies in the event of health deterioration.
- The practice had a strong focus on customer service and reception staff received regular customer service training to ensure they responded positively and reassuringly to patients.
- Reception staff had a good knowledge about patients visiting the practice regularly and were able to alert GPs if they believed something was different or unusual for that patient. Staff knew when patients needed that additional support and provided examples where they had offered support to the bereaved. The administrative team consulted with the reception team to establish the best methods of communication with some of the practice patients.
- All of the 16 patient Care Quality Commission comment cards we received were positive about the service experienced. The cards referred to many aspects of the service they received including long term conditions review, antenatal care, care for children, and urgent care. Results of the NHS Friends and Family Test for 2017 showed 100% of patients would recommend the practice for nine out twelve months.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 237 surveys were sent out and 111 were returned. This represented a return rate of 39% and a practice population response rate of just over 1.5%. The practice's results for its satisfaction scores on consultations with GPs and nurses reflected both local and national results. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG - 90%; national average - 86%.
- 94%% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 96%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 89%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 96% of patients who responded said the nurse gave them enough time; CCG - 95%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful; CCG - 89%; national average - 87%.

Good

Are services caring?

The practice implemented an annual patient questionnaire. The practice provided results for the partial year 2017/18. The campaign was due to finish in March 2018. The results provided showed 561 patients had responded (almost 8% of the patient population), 546 online responses had been received and 15 paper responses. The response showed that 96% of respondents believed the doctors cared for the patients' health and wellbeing and 94% of patients were either very satisfied or fairly satisfied with the overall service they received form the practice.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Staff were alerted to patients with visual or hearing difficulties by means of alerts on patient clinical records.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The GP partners provided patients nearing end of life and their carers with their direct telephone number. We heard examples where the GPs were contacted and provided telephone support and reassurance or visited the patient at home if in need of treatment during the night and at weekends. The GP partners were also very conscious of families and carers and did their utmost to go out and certify patient death quickly. This reduced anxiety for families and carers.

The practice proactively identified patients who were carers by discussing their caring roles during consultations and health checks and using posters in waiting areas asking them to inform the practice of their role. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 147 patients as carers (2% of the practice list). The practice had a Carer's Policy which included details of local support groups such as the Marple Carer's Group and the Marple Dementia Drop In. The practice also signposted carers to advice support groups such as Signpost for Carers (a local charity providing support to unpaid carers in Stockport). Data supplied by the practice showed that they had increased the number of flu vaccinations administered to carers from 80% in 2016/17 to 86% in 2017/18.

Staff told us that if families had experienced bereavement, the practice sent a sympathy card. In addition, the patient's usual GP contacted them to offer support and this was followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Those bereaved patients considered vulnerable and or at risk were reviewed at the practice's monthly multi-disciplinary meetings.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 86%.
- 84% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average -82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views. Feedback received by the practice to their an annual patient

Good

Are services caring?

questionnaire for the partial year 2017/18 showed that 94% of patients stated the GP was very good or good at explaining their health condition and treatment and 96% said their GP was very good or good at listening to them.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and it took account of patient preferences. Staff understood the needs of its population and tailored services in response to those needs. For example

- The culture of the practice was to deliver a person-centred care and treatment service to all its patients. Its objectives emphasised the partnership approach between practice and patients of mutual respect and active involvement of patients in their own care by increasing education, promoting self-care, and offering support and encouragement to lead healthier lives.
- The practice had a good understanding and knowledge of its patient population and had recognised the specific challenges they faced with an ageing population, including high numbers of patients accommodated within nursing and residential care homes, high numbers of patients living in extra care housing and a high number of patients in receipt of packages of home care. In response to these challenges, the practice had implemented a range of support measures to meet the needs of all its population. These included offering regular monitoring home visits, agreeing self-management care and support plans and providing a range of accessible health care services such insulin initiation, blood testing for those on medicines such as blood thinners, in house counselling and ultrasound scanning. These additional services reduced the need for patients to travel to the local hospital.
- The practice reception team were trained in customer service. The practice team emphasised their face to face and telephone approach was essential in promoting positive productive relationships with patients. Reception staff held weekly meetings and one meeting each month was dedicated to customer service and mandatory training. Subjects discussed to support customer service training included reviewing patient feedback, using good service examples, significant events and complaints to promote shared learning and improved customer support. To improve staff communication the practice had a patient communication policy, which supported staff to respond to patients questions in a consistent manner, avoiding ambiguity.
- The practice had a track history of facilitating and supporting the patient forum (patient participation group) and supported their requests to provide health education information. Previously the practice had undertaken audits of potential risk for the practice patient population of developing Cardiac problems, Atrial Fibrillation and Blood Pressure. More recently, the practice had organised a patient education events including Pain (2015) Dementia (2016) and Stockport Together (2017). Patient attendances had grown at these education evenings and at the regular patient forum meetings. These were now held at the nearby Marple Methodist Church. Patients at other local GP practices were invited to the Stockport Together evening and this resulted in about 70 people from Marple attending.
- The patient forum was supported by a virtual (online) patient reference group (PRG). At the time of this inspection, there were 776 members. The practice implemented regular patient polls about different aspects of the service they provided. Recent polls included video consultations. Actions because of this poll included increasing the number of video consultations and offering these at different times of the day. Another patient poll regarding the use of online services had just completed. This showed that of the 285 people who responded to the poll, almost 82% had viewed their medical record online. A further patient poll was being undertaken between January and March 2018 and this was seeking patients' views on access to appointments
- The practice was proactive in offering services at the practice including participating in pilot programmes for the benefit of their patients. In 2017, they had a practice-based physiotherapist, they offered an in-house ultrasound service, and more recently offered a teledermatology service. (Teledermatology is the use of high quality medical photography as a tool to diagnose dermatological conditions.)

Older people:

This population group was rated outstanding because:

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

- The practice recognised their patient population was ageing and implemented a range of strategies to provide pro-active support and care to this population group. All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- As part of the practice's chronic disease management strategy the practice maintained a register of all patients living at home who were housebound.
- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. The practice encouraged patients to attend a falls prevention and bone health service, Steady in Stockport, where a bone and falls risk assessment was undertaken.
- The practice also provided care and support to 82 patients living in a residential and nursing care homes, to 103 patients living in extra care housing, and had the highest population in Stockport in receipt of care packages. Dedicated GP leads were allocated to nursing and residential care homes. Close working relationships were established with community health and care team members including social workers, carers and district nursing teams. Patients considered at risk of unplanned admission to hospital and those discharged from hospital were monitored and supported with self-management care plans.
- In 2017 the practice worked with Stockport Together (a partnership of health care and social care organisations in Stockport to provide joined up services) to provide general medical services to a 'Community Transfer Unit' where patients were transferred from hospital with a programme of re-enablement to promote and assist patients to return back home into the community.

People with long-term conditions:

This population group was rated outstanding because:

- Systems were in place to ensure all patients requiring a review of their long term condition received a comprehensive review and this included medication reviews.
- Longer appointments and home visits were available when needed. All housebound patients with a long term condition (including younger patients) were visited regularly to ensure the appropriate screening was undertaken. All these patients also had a self-management or an advanced care plan in place.
- The practice nurse and healthcare assistant were trained in anticoagulant management and held clinics to monitor patients' blood to determine the correct dose of anti-coagulant medicine. The practice also provided a 24 hour blood pressure monitoring service for both their patients and the locality. The nurse practitioner was a non medical prescriber and was trained to support patients with insulin initiation.
- The nurse practitioner had been researching the effectiveness of holding group consultations for patients with similar long term conditions. Research indicated the support from a peer group assisted patients to better self manage their health condition. Early plans were in place to implement group consultations for patients with diabetes.
- The practice used an integrated video consultation software programme with patients with asthma. The consultation was carried out through the practice's electronic patient record system. A total of 25% of asthma reviews were scheduled for video reviews.

Families, children and young people:

This population group was rated outstanding because:

- The practice also implemented a same day access policy for all children and young people.
- The practice offered a contraceptive service and pre and antenatal care working closely with midwives who carried out a weekly clinic.
- The practice had a local enhanced agreement with the clinical commissioning group (CCG) to provide an in-house vasectomy service to both the practice's patients and patients registered within the Stockport CCG area. The uptake of vasectomies was high; almost 150 vasectomies had been undertaken since April 2017. The practice sent out appointment packs to patients that contained information about the procedure and questions and answers. The patient's own GP was responsible for counselling them, however the GP lead at the practice undertook telephone discussions with patients if requested. Patient written consent was obtained before the procedure was undertaken.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

- Young people had access to the email facility at the practice and so were able to contact a clinician for advice.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

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

This population group was rated outstanding because:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were offered two evenings per week and one Saturday morning each month. Patients were also supported to access weekend appointments at another location in Stockport if this suited them.
- Telephone, email and integrated video consultations were also available and these options supported patients who were unable to attend the practice during normal working hours.
- The practice supported its working age population by enabling them to access advice quickly and effectively through email contact and through the integrated video consultation service. A poll of patients who used the video consultation identified that 60% used it whilst at work.

People whose circumstances make them vulnerable:

This population group was rated outstanding because:

- The practice had a comprehensive palliative and end of life strategy in place and this was supported with clinical protocols.
- The practice held monthly multidisciplinary team meetings where vulnerable or at risk, patients were identified including those newly diagnosed with cancer, recently bereaved and those without appropriate carer support.
- The practice also provided dedicated general medical services to a specialist unit in Stockport (The Meadows) providing end of life care and community healthcare assessments. In addition, the practice was leading a pilot project using this ward as transfer for assessment ward where patients were transferred from hospital with a programme of assessment and support to ensure the right care and support package was identified for the patient to assist them to return back home.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

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

This population group was rated outstanding because:

- The practice provided general medical services to a 'step down ward' for patients with delirium. The GP led the clinical team on the ward and visited daily Monday to Friday. They worked closely with nurses, social workers and psychiatrists. The practice confirmed that 80% of these patients eventually returned home.
- One GP was the lead for a large nursing home providing care to patients with mental health issues including dementia. They provided weekly visits and worked with staff and carers to develop and agree advanced care plans. The practice had recognised the anxiety and distress caused to families and designated next of kin and carers of patients accommodated in residential and nursing dementia care home settings. To support these family members and carers the practice offered half hour appointments to discuss their relative's health and treatment plan. We heard examples where these meetings had lasted up to an hour and half had included several family members, some attending via telephone conference.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. To administrative team consulted the reception team on how best to communicate with some patients as the reception team had a good insight and understanding of patients' specific needs.
- The practice offered in-house counselling to patients assessed with low level mental health concerns.

Timely access to the service

The practice was committed to monitoring patient demand for appointments alongside the practice's capacity to meet that demand. They adapted the appointments system and appointment scheduling to try to meet demand. For example, in 2017, in response to an unexpected reduction

in the availability of GPs, the practice trialled a system of offering open surgeries. Following the return of the GPs, the practice reverted to a system of on the day urgent appointments, routine and pre-bookable appointments.

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs. The practice offered a range of alternative appointment to enable patient access to appointments for GP and clinician advice. These included the use of video consultations. Patients could also email GPs with any queries or minor issues.

Patients had timely access to initial assessment, test results, diagnosis and treatment. Comprehensive weekly checks were undertaken to monitor the workflow and task allocation.

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher when compared to local and national averages. This was supported by observations on the day of inspection, feedback from patients we spoke with and completed comment cards.

- 89% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 82% and the national average of 80%.
- 90% of patients who responded said they could get through easily to the practice by phone; CCG – 77%; national average - 71%.
- 91% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 79%; national average - 76%.
- 89% of patients who responded said their last appointment was convenient; CCG - 86%; national average - 81%.
- 91% of patients who responded described their experience of making an appointment as good; CCG - 78%; national average - 73%.
- 70% of patients who responded said they do not normally have to wait too long to be seen; CCG - 60%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. Staff were trained in customer service and knew how to respond to issues and complaints raised by patients.
- The complaint policy and procedures were in line with recognised guidance. The practice manager was the designated complaint manager and responded to complaints in accordance with the practice's policy. Between April 2017 and the inspection in February 2018, 13 complaints had been received. We reviewed a sample of these and found that they were handled appropriately, offering an apology as required and in a timely way.
- The practice learned lessons from individual concerns and complaints and action was taken as a result to improve the quality of care. Evidence showed that where complaints were about specific individuals the staff involved reflected on their own practice and offered apologies where appropriate.
- The practice also logged positive feedback from patients and examples of where staff had been effective in managing a situation or conversation. These were logged as Good Service Examples (GSE). The practice used these examples to assist learning and development, improve customer service and promote a consistent and supportive approach to patients.
- The practice gathered feedback from patients through the patient forum, the patient reference group (PRG) and through surveys and complaints received. The practice implemented regular patient polls about different aspects of the service they provided.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice, and all of the population groups, outstanding for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure the continuing resilience of the practice to deliver high quality services.
- The practice leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges affecting their patient population and the local area population. The practice leaders attended meetings to contribute to wider service developments and frequently participated in a range of pilots to bring services closer to the practice patient population.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff reported a positive, happy atmosphere and easy access to advice and support.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The practice's mission statement, 'A caring and progressive healthcare team. Striving for excellence supporting you to lead a healthier life' was displayed in the practice and the practice objectives were included in the patient information leaflet. The practice values were driven by the management team and embraced by all practice staff we spoke with. Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.
- There was a commitment by all the practice staff to deliver a quality service. The practice's comprehensive strategy and supporting business plans reflected the vision and values. The practice Strategy and Improvement Plan was supported by a range of other plans and strategies such as the Clinical Strategy, Core Goals and Principles for 2018 and an annual training and staff support strategy. The practice held weekly clinical and administration meetings. A rolling programme of planned topics were discussed at these meetings. Community healthcare professionals were invited to palliative care meetings and virtual meetings were held with health visitors as required for safeguarding concerns.
- The practice strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. The practice's underpinning ethos was that the patient was central to all its activities. It involved patients in contributing and developing the services provided, seeking feedback from patients through varied online patient polls, promoting patients' health education and supporting self-care.
- A comprehensive system of continuous quality review was implemented to monitor progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Each staff member was encouraged and supported to shine at what they did. They were proud experts in their areas of responsibility.
- There was an individual and team ethos of commitment to delivering the best services to patients. The whole practice team fostered a culture of 'can do' and patient care and customer satisfaction was central to everything the practice did. There were positive relationships between staff and teams.
- We saw that the practice focused on the needs of patients. All weekly clinical staff meetings were minuted with detailed actions to improve the quality of care for patients. There was an overarching focus on providing high quality patient centred care and customer care.
- Clear performance objectives at organisational, team and individual level were in place and staff were supported to always work to the practice's vision and values.

Are services well-led?

Outstanding

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

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff viewed these as learning and development opportunities. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. The practice leaders offered an open door policy.
- The practice encouraged staff members to share with all the team the positive feedback they received from patients and users of their service by emailing the whole team. Staff found these rewarding. A log of these emails were maintained.
- There were processes for providing all staff with the development they needed. This included regular one to one meetings, team meetings, appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff were all involved in staff celebrations and planning team-building days.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Governance arrangements were proactively reviewed and reflected best practice. For example, the annual strategy/improvement plan was supported with a monthly audit plan, which identified for example which clinical audits were required each month, what clinical protocols required review and what care plans required review. The audit calendar identified who was responsible for the activity and the expected completion date.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- As part of the quality improvement/assurance cycle all aspects of practice activity was monitored and reviewed. This helped to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The practice had processes to manage current and future performance. Performance of clinical staff was monitored supportively within a culture of learning and development and this could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice leaders had oversight of patient safety, incidents and complaints, and appropriate action was taken.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- The practice employed a range of administrative staff with specific areas of leadership and responsibility that

included monitoring of achievements in meeting the practice's internal standards and performance indicators. This included ensuring patients requiring health care reviews were called in for these.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients following patient surveys and feedback through the patient forum.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information, which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were comprehensive arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services. There were consistently high levels of constructive engagement with people who used services, including all equality groups and the staff. Constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. Services were developed with the full participation of those who used them, staff and external partners. For example:

- The practice had a patient forum group which had about 12 active members who met regularly every eight weeks. The attendance of patients at these groups had grown and the meeting were now held at Marple Methodist Church. Meeting minutes were available on the practice website and these demonstrated that the practice responded to requests for improvements such as fitting external lighting to the car park and the pathway into the practice building.
- The practice also ran an annual patient questionnaire available to all patients in both paper and electronic format. The campaign was due to finish in March 2018.
- The practice monitored feedback through the Friends and Family Test and this showed positive responses each month.
- The service was transparent, collaborative and open with stakeholders about performance including sharing lessons learnt from serious events.
- The practice engaged with the CCG and attended meetings to contribute to wider service developments. The non-clinical practice partner was the non-executive director for Viaduct Health and the Alliance Practice Manager Lead for the Northwest. One GP partner was the Stockport CCG Vice Chairperson, the CCG Cancer Lead and the Marple / Werneth locality Lead and the third GP partner was the Executive Director for Viaduct Care and the GP neighbourhood Lead for Marple. The nurse practitioner was on the executive board nurse at Bury CCG.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice, this included development of protocols following serious events, improving administrative systems after complaints, responding to data in relation to prescribing and an ongoing review of how to offer better access to appointments.
- The practice was a long-standing teaching and training practice, two partners were trainers and as a result of training the practice had been able to recruit GP partners from the scheme. The practice supported medical students and trainee GPs with their education. The practice used this resource effectively to develop skills and abilities by delegating responsibility to undertake planned and co-ordinated clinical audits to evaluate and progress the quality of the services provided.

Are services well-led?

Outstanding

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

- The practice has a history of forward thinking and innovation. They had won awards previously for their innovative approaches to providing patient care. The practice continued with its innovative approach introducing and promoting the integrated video patient consultations and implementing plans to offer group consultations for patients with a long term health condition such as diabetes.
- The practice was proactive in participating in pilot schemes for the benefit of their patients for example offering on-site physiotherapy, and for the wider community providing GP care to the Community Transfer Unit under the re-enablement agenda.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.