The Birches Medical Centre

Inspection report

Polefield Road
Prestwich
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

We carried out an announced comprehensive inspection at The Birches Medical Centre on 10 April 2018 as part of our inspection programme.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided through regular clinical audits and reviews of the service delivered. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff met regularly to discuss patient care and practice related issues. Some records of the meetings held were very brief.
- Medicines were well managed and prescriptions were stored securely.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Some patients found it difficult to get through to the practice by phone to book an appointment.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- Curtains used in clinical rooms should be washed at least every six months and records kept of this activity.
- Meeting notes should include more detailed information to keep staff informed about matters discussed and to ensure issues identified were followed-up and monitored.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC inspector and included a GP specialist adviser.

Background to The Birches Medical Centre

The Birches Medical Practice provides general medical services to 4250 patients within the Bury Clinical Commissioning Group area.

Services are provided from: Polefield Road, Prestwich, Manchester M25 2GN

The practice website is: www.thebirchesmedicalcentre.co.uk

Information taken from Public Health England placed the area in which the practice is located as number six on the deprivation scale of one to ten. (The lower the number the higher the deprivation). In general, people living in more deprived areas tend to have greater need for health services.

The out of hours provider to the practice is BARDOC (Bury and Rochdale Doctors on Call)

The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, extended hours, support for patients with dementia and learning disabilities, influenza and pneumococcal immunisations and minor surgery.

There are three GPs working at the practice; one senior partner (female), one partner (male) and a salaried GP (female). The GPs work between three and six sessions per week. There is also an advanced nurse practitioner, three practice nurses and a health care assistant. There is a practice manager and a team of administration / reception staff.

The practice's regulated activities are:

Surgical procedures

Treatment of disease, disorder or injury

Family planning

Diagnostic and screening procedures

Maternity and midwifery services

Good

Are services safe?

We rated the practice and all of the population groups as good for providing a safe service .

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (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 took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. An infection control audit was carried out in October 2017. The practice was rated as amber which indicated a medium risk. The issues highlighted had been addressed by the practice manager.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- Newly recruited staff received induction training and a record was kept of the issues addressed.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- A pharmacist employed by the Bury Clinical Commissioning Group worked at the practice one day a week. Their role was to support the GPs and clinical staff in monitoring the use of medicines prescribed and to carry out patient reviews to help them better understand their medication.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements. For example, small electrical equipment was tested and medical equipment was calibrated. There was a fire marshal appointed to different areas of the building and staff had completed fire safety training. Fire safety information was displayed and a fire drill had recently taken place. Fire safety risk assessments had been carried out.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing an effective service .

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 patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs using the practice At Risk identification system.
- The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- 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 appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans were updated to reflect any extra or changed needs. Medicines prescribed to patients by a doctor at a hospital were not automatically added to patients' records.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Influenza and shingles vaccinations were available.
- The practice nurse carried out home visits for patients who were unable to attend the surgery.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Chronic disease specific clinics were run by specialist nurses. For example, an asthma clinic and a stroke clinic were regularly held.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Influenza vaccinations were available for all patients with chronic conditions.
- All cancer cases were reviewed and patients diagnosed outside the two week wait rule were treated as a significant event and the Bury Clinical Commissioning Group were informed.
- The practice pharmacist worked with asthma/COPD patients to help them better understand their medicines.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Good

Are services effective?

- Patients with coeliac disease were offered yearly reviews.
- There was an active management plan for children with asthma. All of these patients had a personalised care plan and inhaler technique training.
- Flu vaccinations were offered. The practice offered the nasal influenza for children within the risk groups.
- All staff were up to date with safeguarding training.

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

- 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 40-74. 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:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. An alert was also placed on the patient's records to alert staff of this information.
- **The practice had a designated safeguarding lead for both children and adults, and all staff were fully aware of safeguarding procedures if they had concerns.**
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a system for reviewing vulnerable patients who did not attend their GP or hospital appointment.
- Regular safeguarding meetings took place.
- All staff were trained in safeguarding procedures.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 96% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the CCG average of 91% and the national average of 84%.
- 100% 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 above the CCG average of 95% and the national average of 92%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the CCG average of 94% and the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual and six monthly health checks to patients with a learning disability.
- Patients on lithium therapy had a three month recall appointment for blood tests

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided through regular clinical audits. For example, clinical audits were carried out in relation to patient with osteoporosis, acute kidney disease and bowel cancer. The quality of the audits was very good and a second cycle audit had been completed. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Good

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out medicine and health reviews for people with long term conditions, older people and people requiring contraception.
- 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 understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- Regular clinical meetings were held to discuss patient care. The records we looked at showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. However, we found that detailed records of the meetings were not always kept which would ensure issues identified were followed-up and monitored.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes by the practice pharmacist.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

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.
- 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.

Please refer to the Evidence Tables for further information

Good

Are services caring?

We rated the practice and all of the population groups as good for providing a caring service.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated patients.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- 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 practice proactively identified carers and supported them. For example, a member of staff acted as a carers champion. They provided carers with information about NHS health checks and support services in the local community.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice and all of the population groups as good for providing a responsive service.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- 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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Wheelchair access was available and a wheelchair was available for use when in the practice.
- The premises were user friendly for disabled people as the building was on one level.
- The practice was visually impaired friendly and a Guide Dog policy was in place
- There was a hearing aid loop for patients with a hearing impairment.

Families, children and young people:

- 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.
- All parents or guardians calling with concerns about a child under the age of 12 were offered a same day urgent appointments when necessary.
- Baby changing facilities were provided.
- There was a childhood immunisation clinic with appointments available around school times.

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

- 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 and Saturday appointments.
- Wi-Fi was available.
- Online appointments, access to the extended hours service and telephone consultations were available to patients unable to attend the surgery during normal working hours.
- Pre bookable appointments were available four weeks in advance.
- NHS health checks were available.
- The Meningitis ACWY vaccination was available for students. The Men ACWY vaccine provides good protection against serious infections caused by four different meningococcal groups (A, C, W and Y) including meningitis and septicaemia.
- Appointments were available from 8am with the healthcare assistant and advanced nurse practitioner.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode
- Two of the GPs spoke Polish which supported those patients who were unable to speak English.
- The drug and alcohol worker held regular individual support sessions at the practice.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Carers of patients with dementia were provided with information about support services including a dementia advisor
- Longer appointments were available for these patients.

Timely access to care and treatment

Most patients reported they were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

The practice used a range of methods to gather patient feedback which included internal surveys, questionnaires and the Friends And Family Test (FFT). A number of patients reported in the FFT questionnaires that the appointment system was not easy to use. They raised concerns that they found it difficult to get through to the practice to book an appointment. This issue was also reflected in the CQC comment cards. In light of this the practice conducted a survey with patients to identify how they could improve access to appointments. They had addressed some of the concerns raised by patients by introducing more telephone lines and increasing face to face appointments and telephone appointments with GPs and other clinical staff.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The 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 monitored progress against delivery of the strategy.

Culture

The practice had consistently provided high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- There was a staff disciplinary procedure to manage staff whose performance was not in line with the practice vision and values of providing high quality care.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. 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.
- There were processes for providing all staff with the development they need. This included 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. For example, one of the practice nurses was planning to begin a training course in advanced diabetes care.
- Clinical staff 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.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff said they felt they were treated equally.
- There were positive relationships between staff and teams.

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. 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. For example, small electrical equipment had been checked for its safe use and equipment used by clinical staff had been calibrated to ensure it was in good working order.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- 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.

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.
- 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 submitted data or notifications to external organisations as required.
- There were robust 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, staff and external partners to support high-quality sustainable services.

A full and diverse range of patient and staff views and concerns were encouraged, heard and acted on to shape services and culture. There was an active Patient Participation Group (PPG). We spoke with a member of the PPG. They told us the group met regularly to discuss any practice related issues and that the practice manager and a GP always attended the meetings. They said they felt listened to and included in decision making. Their views and ideas were taken on board when possible and they were always treated with respect.

- A quality assurance survey was completed by the practice. The findings of the survey were collated with action taken to address the issues raised. For example, patients were asked about their experience of accessing appointments by phone. In light of the negative comments, additional telephone lines and appointments were made available.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had improved patient access to appointments although they continued to monitor this part of the service.
- The practice nurse had completed their independent nurse prescriber training which meant they could prescribe medicines within the scope of their responsibility.
- The practice had achieved 100% of the Greater Manchester standards.

Please refer to the Evidence Tables for further information.