Davyhulme Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Davyhulme Medical Centre was inspected on the 8 January 2015. This was a comprehensive inspection.

We rated Davylhulme Medical Practice as good in relation to being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence.

Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They said that were treated with respect, in a polite manner and as individuals.

A system was in place to ensure the practice was regularly cleaned. A system was in place for managing Infection prevention and control.

Patients had good access to medical care and we were assured that if a patient needed to be seen they could access a GP appointment on the same day.

We saw areas of outstanding practice including;

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between patients, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the practice management team. We observed practice staff to be respectful, pleasant and helpful with patients and each other during our inspection visit.

To improve patient access the practice had (in response to patients views expressed in the practice's own patient survey) extended the practice opening hours and reviewed and implemented a new appointments system in July 2014.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is responsive. The practice reviewed the needs of their local population and engaged with NHS England and Trafford Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people
The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments.

Good

People with long term conditions
Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good

Families, children and young people
Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Good

Working age people (including those recently retired and students)
The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Good

People whose circumstances may make them vulnerable
The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people with learning disabilities. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations and had arranged for

Good

Summary of findings

a welfare benefits advisor to be accessible at the practice once a week. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. People in vulnerable circumstances were able to register with the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice had carried out annual health checks for people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations such as MIND. The practice had a system in place to follow up on patients who did not attend practice appointments or had attended accident and emergency.

Summary of findings

What people who use the service say

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

Patients we spoke with and who completed our comment cards were very positive about the care and treatment provided by the doctors and nurses and the support provided by other members of the practice team. They also told us that they were treated with respect and their privacy and dignity were maintained. The representatives of the PPG told us they met with the practice management team regularly, were consulted appropriately and that their views were respected and valued.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

What this practice does best;

93% of respondents described their overall experience of this surgery as good. CCG (regional average: 89%).

86% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. (CCG regional average: 84%).

69% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care. (CCG regional average: 69%).

What this practice could improve;

39% of respondents usually wait 15 minutes or less after their appointment time to be seen. (CCG regional average: 71%).

57% of respondents with a preferred GP usually get to see or speak with that GP. (CCG regional average: 65%).

70% of respondents are satisfied with the surgery's opening hours. (CCG (regional) average: 78%).

289 surveys sent out. 108 surveys back. 37% completion rate.

Outstanding practice

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between patients, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the practice management team. We observed practice staff to be respectful, pleasant and helpful with patients and each other during our inspection visit.

To improve patient access the practice had (in response to patients views expressed in the practice's own patient survey conducted) extended the practice opening hours and reviewed and implemented a new appointments system in July 2014.

Davyhulme Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice nurse advisor). Our inspection team also included an Expert by Experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive.

Background to Davyhulme Medical Centre

Davyhulme Medical Centre is situated in the Davyhulme area of Trafford. At the time of this inspection we were informed 11,800 patients were registered with the practice. The Davyhulme Medical Practice population experiences lower levels of income deprivation affecting children and older people than the practice average across England. There is also a higher proportion of patients above 65 years of age (19.5%) than the practice average across England (16.53%). 59.3 per cent of Davyhulme Medical Practice Patients have a longstanding medical condition compared to the practice average across England of 53.54%.

A wide range of medical services are provided at the practice (details of which are provided on the practice website). At the time of our inspection 7 partner GPs, 1 salaried GP, 1 locum GP and 2 registrar GPs were providing general medical services to patients registered at the practice. 3 of the GPs are male and 8 are female. The GPs are supported in providing clinical services by 1 practice pharmacist (female), 3 practice nurses (female) and 2 health care assistants (female). Clinical staff are supported by the 21 staff in the practice team. This team are led by the practice management team comprising of a 1 general manager, 1 patient services manager, 1 clinical administrator and 1 finance manager.

Davyhulme Medical Centre is accredited by the North Western Deanery of Postgraduate Medical Education as a GP Training Practice.

Davyhulme Medical Centre contract with NHS England to provide General Medical Services (GMS) to the patients registered with the practice.

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

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 8 January 2015 and spent eight hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received four completed CQC comment cards, spoke with seven patients at the time of our inspection and three members of the practice's patient participation group (PPG) prior to our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with the partner GP who is the registered manager, three of the other partner GPs, one GP registrar, one of the practice nurses one of the health care assistants, the practice pharmacist and medicines manager, three of the practice management staff and three members of the practice team who were working at the time of our visit.

Good

Are services safe?

Our findings

Safe Track Record

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

Learning and improvement from safety incidents

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

The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were emailed to the GPs and practice nurses and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

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

The systems alerted the GPs, nurse practitioner and practice nurses when a safeguarding issue or safeguarding plan had been identified and developed for individual patients. We also saw that the practice team were communicating regularly with the safeguarding leads for children and adults at Trafford social services and Trafford CCG when required and provided reports to them when requested to do so. We looked at two recent examples where clinicians had identified potential patient safeguarding issues. All had been reported promptly to the relevant safeguarding authority. Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. We also saw evidence that GPs had received regularly updated enhanced (level 3) children's safeguarding training.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. Staff were provided with training to ensure that chaperoning was safe and effective. All staff performing chaperone duties had been subject to a Disclosure and Barring Service (DBS) check. Information about having a chaperone present was prominently displayed in the practice waiting areas, consulting and treatment rooms and on the practice website. No issues in respect of chaperoning were raised by patients we spoke with or received information from.

Medicines Management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of the clinical staff at the practice. The practice clinical staff were supported by a practice pharmacist and medicines

management team. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions. This included patients being able to request a repeat prescription online. It was established practice to monitor the amount of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained. We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date.

Cleanliness & Infection Control

We looked around the practice during our visit. Systems were in place for ensuring the practice was regularly cleaned. We looked at records that reflected a cleaning schedule and a risk assessment process was in place. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control. One of the practice nurses provided leadership in this area. Staff had been provided with regular infection prevention and control training and this included the use of appropriate hand washing techniques. We saw that appropriate hand washing facilities (including liquid soap and disposable towels) and instructions were available throughout the practice. Checks (audits) had been conducted to ensure actions taken to prevent the spread of potential infections were maintained. The last audit in May 2014 had identified some action points and we established these had been addressed.

We also saw that practice staff were provided with equipment (for example goggles and disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients.

The practice was registered and contracted to carry out minor surgical procedures. We looked at the treatment room used for carrying out minor surgical procedures. This room was clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place and medical instruments used for minor surgical procedures were disposed of after single use. Unused medical instruments and dressings were stored in sealed packs. We looked at these and found all to be within the expiry date stipulated on the packs.

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

The practice water system had been routinely tested for legionella bacteria (that could potentially cause a serious infection) in October 2014. No legionella bacteria was found and no action was required. We noted that a more detailed check of the practice water systems had been arranged to be conducted at the end of January 2015.

Equipment

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

Staffing & Recruitment

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

We looked at staff recruitment practices and records. A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body, for example The

Good

Are services safe?

General Medical Council (GMC). Also a Disclosure and Barring Service (DBS) check had been conducted to assess the person's suitability to work with potentially vulnerable people.

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, was readily accessible to staff. Records and discussion with staff demonstrated that all clinical and non-clinical practice staff received annual basic life support training (the most recent was October 2014). We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice. The plan had been developed in conjunction with Trafford CCG.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice was structured, organised and had introduced systems to ensure best practice was followed. Practice was evidence based and underpinned by nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies which were used to inform best practice. We saw that such standards and guidelines were easily accessed electronically by clinicians.

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

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to breast screening, melanoma referrals and theophylline prescribing. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that where audits identified actions these were clearly described and communicated to staff. If necessary a timescale for re-auditing was identified.

We saw evidence of peer review and support and regular clinical and practice meetings being held to monitor and identify possible issues and improvements in respect of clinical care.

The GPs, practice nurses and administration staff had developed areas of expertise and provided advice and support to colleagues in respect of these areas.

Feedback from patients we spoke with, or who provided written comments, were complimentary about the quality of the care and treatment provided by the staff team at the practice.

Effective staffing

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. New staff were provided with a programme of induction that included training relevant to their role. We saw that appraisals took place regularly and included a process for documenting, action planning and reviewing appraisals.

GP's were supported to obtain the evidence and information required for their professional development, annual appraisals and periodic revalidation. This is where doctors demonstrate to their regulatory body, the GMC, that they are up to date and fit to practice. The practice was also accredited as a GP training practice by the North Western Deanery of Postgraduate Medical Education, providing experience for two GP registrars. A GP registrar is a qualified doctor undertaking post graduate general practice training.

Working with colleagues and other services

We saw that appropriate processes were in place that ensured patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine. Patients we spoke with, or received written comments from said that where they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. The practice had established well developed links with Trafford carers team.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings

Good

Are services effective?

(for example, treatment is effective)

with professionals such as health visitors to discuss child health and safeguarding issues and McMillan nurses and district nurses to plan and co-ordinate the care of patients coming to the end of their life. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hours service. The practice provided detailed clinical information to the out of hours service about patients with complex healthcare needs. Also all patient contacts with the out of hours provider were reviewed by a GP the next working day.

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

Information Sharing

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

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment.

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

Health Promotion & Prevention

New patients, including children, were provided with appointments to establish their medical history and current health status. This enabled the practice to identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma.

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

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

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Information we received from patients reflected that practice staff interacted with them positively and empathetically. They told us that staff at the practice treated them with respect, in a polite manner and as an individual.

There was a strong, visible, person-centred culture operating at the practice. All our discussions with staff evidenced the importance of this culture when patients were being provided with care and treatment. We observed practice staff to be respectful, pleasant and helpful with patients and each other during our visit.

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

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

Care planning and involvement in decisions about care and treatment

We looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The 2014 GP patient survey reported that 73% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 69% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon. The 2014 GP patient survey reported that 89% of respondents said the last GP they saw or spoke to was good at listening to them. 78% of respondents said the last nurse they saw or spoke to at the practice was good at listening to them.

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

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

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patient's care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patients carers. Information about how to access Trafford carers centre was available in the reception area and a member of the centres carers team attended the practice on a monthly basis to provide advice to patients and their carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that meet patient's needs.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. There was a mix of male and female GPs at the practice and this enabled patients to see a GP of the same sex if preferred. Longer appointments could be made for patients such as those with long term conditions or who were carers. Home visits were provided to patients whose illness or disability meant they could not attend an appointment at the practice.

The GPs and practice nurses had developed areas of special interest and expertise and took 'the lead' in particular clinical areas. These clinical areas included considering the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice carried out (and recorded) regular checks on how it was responding to patients' medical needs. This activity analysis was shared with Trafford CCG and formed a part of the quality framework monitoring. It also assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews.

Systems were in place to identify when people's needs were not being met and informed how services at the practice were developed and planned. A variety of information was used to achieve this. For example profiles of the local prevalence of particular diseases, the level of social deprivation and the age distribution of the population provided key information in planning services. Significant events analysis, individual complaints, survey results and clinical audits were also used to identify when patients needs were not being met. This information was then used to inform how services were planned, developed and provided at the practice.

Davyhulme Medical Centre is housed in a purpose built building that opened in 2009. The practice has a reception area, patient waiting areas and a suite of consultation and treatment rooms. There are also facilities to support the administrative and development needs of the practice including office provision and a meeting room. The building was easily accessible to patients (including those with a disability).

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to individual needs and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment including those with a learning disability, dementia or who had mental health needs.

Access to the service

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

Patients commented positively in respect of being able to access the service. We also looked the results of the 2014 GP survey. 78% of the respondents found it easy to get through to the practice by phone. 84% were able to get an appointment to see or speak to someone the last time they tried and 87% said the last GP they saw or spoke to was good at giving them enough time. Also 93% said the last appointment they got was convenient and 75% described their experience of making an appointment as good.

Patients had good access to medical care and we were assured and observed that if a patient needed to be seen they could access a GP appointment on the same day. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas and on the practice website. To improve patient access the practice had (in response to patients views expressed in the practice's own patient survey conducted) extended the practice opening hours and reviewed and implemented a new appointments system in July 2014. Consultations with the practice nurses were by appointment. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. This information was also provided on the practice website.

GP consultations were provided in 10 minute appointments. Where patients required longer appointments these could be booked by prior arrangement.

Are services well-led?

Good

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

Our findings

Vision and Strategy

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

One of the partner GPs described to us a clear value system which provided the foundations for ensuring the delivery of a high quality service to patients. The culture at the practice was open and fair. Discussion with members of the practice team, the patient participation group and patients generally demonstrated this view of the practice was widely shared.

Governance Arrangements

There were clearly defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular clinical and practice meetings for staff. One of the partner GPs was the lead for clinical governance at the practice (this role rotated amongst the other partners on a yearly basis). We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. The contents of the minutes we looked at and discussion with GPs, nursing staff and other members of the practice team showed that the fair and open culture at the practice enabled staff to challenge existing processes and practices to enhance the quality of the services provided.

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

The practice had a system in place for completing clinical audit cycles. These are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to urinary tract infections and diabetes. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that where audits identified actions these were clearly described and communicated to staff through clinical meetings and the practice's internal electronic communication system. Where appropriate a timescale for re-auditing was identified.

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

Leadership, openness and transparency

A clear leadership structure was in place. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes and discussion with staff that clinical and staff meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings or at individual appraisal meetings. They also told us that senior staff at the practice operated an 'open door' policy and that they could take issues to them at anytime (if they felt the need to) and did not have to wait for more formal meetings to do so.

Senior members of the practice team told us of plans for developing the quality and range of services provided at the practice. This included plans for managing future changes at the practice and for increasing collaboration with other local practices. Whilst these plans were not formally documented it was clear from our discussions with the practice team that they were aware of possible changes and plans for the future of the practice.

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

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the 2014 practice patient survey

Are services well-led?

Good

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

and the 2014 GP patient survey that reflected high levels of satisfaction with the care, treatment and services provided at Davyhulme Medical Centre. Where issues were identified action had been taken to address them.

The practice had an active patient participation group (PPG). We spoke with three members of the PPG prior to our visit to the practice. They told us that when issues were identified the PPG was consulted and encouraged to engage in the development of ways to address them. They said their contributions and views were respected and values. The practice website encouraged and enabled patients to provide feedback and suggestions about the services provided and to join the PPG.

The practice had gathered feedback from staff through clinical and staff meetings, one to one staff appraisals and informal discussions. Those we talked with told us they were able to give feedback and discuss any concerns or issues with colleagues and management and that their contributions were respected and valued. They also said that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt fully involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff we spoke with told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive in enabling them to access training relevant to their role.

GPs were supported to obtain the evidence and information required for their professional development, annual appraisals and periodic revalidation. This is where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they are up to date and fit to practice. The practice was also an accredited as a GP Training Practice by the North Western Deanery of Postgraduate Medical Education, providing experience for up to two GP registrars. A GP registrar is a qualified doctors undertaking post graduate general practice training. Placements were also provided for medical students at the practice.

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