Ashworth Street Surgery

Quality Report

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Date of inspection visit: 12 February 2015
Date of publication: 09/04/2015

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Ashworth Street Surgery was inspected on 12 February 2015. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We rated the practice as good overall, outstanding in relation to being responsive and good in respect of being safe, effective, caring and well-led.

Our key findings were as follows:

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.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Patients informed us that their privacy and dignity was always respected particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation room.

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.

The practice had gathered feedback from patients through the yearly practice patient survey and through comments and complaints received. We looked at the results of the January 2015 GP patient survey and the last survey conducted by the practice. Both of these reflected high levels of satisfaction with the care, treatment and services provided. However if issues were identified action had been taken to address them.

We saw areas of outstanding practice including:

A primary prevention initiative was also in place aimed at providing specific health screening for the practice's

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younger Asian population to detect early signs of disease that had a higher prevalence in this group than the rest of the population. The initiative included staff going into local schools to promote the importance of such screening.

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was responsive to people's needs, was kind and promoted people's dignity. Relationships between patients, those close to them, and staff were strong, responsive 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. In 2014 one of the GPs received a special memorial award at the Heywood, Middleton and Rochdale Clinical Commissioning Group (special thanks and recognition) Awards. Two other clinicians at the practice had also been nominated. Awards are made by local people and patients nominating local GP practice staff who are thought to deserve special thanks and recognition.

To improve patient access to services the practice opened a branch surgery at nearby Norden in 2012. Surgeries are provided from Monday to Friday by two GPs. The branch surgery had been developed in response to the views of patients and the patient participation group (PPG). It has greatly improved access to the practice for older and less mobile patients who live in the Norden area of Rochdale.

The practice had a very pro-active patient participation group (PPG) which has been in existence since October 2011. They provided a regular presence at the surgery to engage with their fellow patients to establish their views and promote various health initiatives in partnership with the practice team. The group had also actively supported the vaccination clinics for flu and shingles and the bi-annual health events that were held (on Saturdays) to target patients who seldom attended the practice. They had also been supporting another local practice in the development of their own PPG.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing well when compared to neighbouring practices in the CCG.

Are services caring?

Good

The practice is rated as good for providing caring services. Data demonstrated that 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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their

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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 in place to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very proactive. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments. Patients over 75 years had a named accountable GP to aid continuity of care. The practice had undertaken care plans for the 2% of patients most at risk of admission in this population group and reviewed these every 3 months. The practice worked closely with the community matron to coordinate the care of elderly patients with complex health needs. To improve patient access the practice had extended hours on a Monday and Wednesday (630pm to 8pm) and provided Saturday morning appointments once per month (8am to 11am. To improve access for older patients the practice opened a branch surgery at nearby Norden in 2012.

People with long term conditions

Good

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. To improve access for less mobile patients the practice opened a branch surgery at nearby Norden in 2012. Patients with long-term conditions had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the practice clinicians worked with relevant health and care professionals to deliver a multidisciplinary package of care. During reviews of long-term conditions patients were advised about self-managing their condition, were signposted to appropriate support groups and given health promotion advice. When patients did not attend this was followed up to determine the reason and provide an alternative appointment. One of the nurse practitioner's roles was to contact difficult to engage patients to encourage them to make convenient/flexible appointments to improve uptake of care and treatment. Bi-annual health events were held (on Saturdays) to target patients who seldom attended the practice. They were provided with a series of health checks. Health trainers also provided a wide range of health promotion information during these events. These events were also attended and actively supported by the practice's very pro-active patient participation group (PPG) to help maximise patient engagement.

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Families, children and young people

Good

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. The weekly baby clinic had been structured to ensure that care was provided utilising a multi-disciplinary approach. Parents had access to health visitors, nursing staff and doctors. A primary prevention initiative was also in place aimed at providing specific health screening for the practice's younger Asian population to detect early signs of disease that had a higher prevalence in this group than the rest of the population. The initiative included staff going into local schools to promote the importance of such screening.

Working age people (including those recently retired and students)

Good

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. To improve patient access the practice had extended hours on a Monday and Wednesday (630pm to 8pm) and provided Saturday morning appointments once per month (8am to 11am). Face to face and telephone appointments were available and the Practice provided an on line facility to make appointments the day before so that workers have the facility to book an appointment after work. On line appointments were also offered up to six months in advance. Every surgery session included two pre-bookable telephone consultations. Doctors would phone patients after surgery if needed. Students who are leaving to go to university are reassured they can become temporary residents or re-join the practice. Advice was available regarding safe sex and sexually transmitted infections screening. Some of the GP partners had undertaken Sexual Health training. Bi-annual health events were held (on Saturdays) to target patients who seldom attended the practice. They were provided with a series of health checks. Health trainers also provided a wide range of health promotion information during these events. These events were also attended and actively supported by the practice's very pro-active patient

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participation group (PPG) to help maximise patient engagement. One of the nurse practitioner's roles was to contact hard to engage patients to encourage them to make convenient/flexible appointments to improve uptake of care and treatment.

People whose circumstances may make them vulnerable

Good

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. 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. There were no barriers to people in vulnerable circumstances being able to register with the practice.

People experiencing poor mental health (including people with dementia)

Good

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. There was a system in place to follow up on patients who did not attend practice appointments or had attended accident and emergency where there may have been mental health needs. The practice was providing primary health care services to a local residential service for adults with complex mental health needs.

Summary of findings

What people who use the service say

We received 47 completed CQC comment cards, spoke with eight patients on the day of inspection and four members of the practice's patient participation group (PPG) prior to and during 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 complimentary about the care and treatment provided by the doctors and nurses and the support provided by other members of the practice team. They told us that their privacy and dignity was maintained and that they were treated with respect. The representatives of the PPG told us they met with the practice management team regularly and provided us with several examples where they had actively worked with the practice to deliver health promotion events and encourage patients to access the services of the practice

We also looked at the results of the January 2015 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;

96% of respondents would recommend this surgery to someone new to the area. (Local CCG average: 74%).

87% of respondents describe their experience of making an appointment as good. (Local CCG average: 67%).

78% of respondents find it easy to get through to this surgery by phone. (Local CCG average: 63%).

The remaining results were broadly in line with the local CCG average.

303 surveys sent out. 103 surveys back. 34% completion rate.

Outstanding practice

A primary prevention initiative was also in place aimed at providing specific health screening for the practice's younger Asian population to detect early signs of disease that had a higher prevalence in this group than the rest of the population. The initiative included staff going into local schools to promote the importance of such screening.

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was responsive to people's needs, was kind and promoted people's dignity. Relationships between patients, those close to them, and staff were strong, responsive 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. In 2014 one of the GPs received a special memorial award at the Heywood, Middleton and Rochdale Clinical Commissioning Group (special thanks and recognition) Awards. Two other clinicians at the practice had also been nominated. Awards are made by local people and patients nominating local GP practice staff who are thought to deserve special thanks and recognition.

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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 manager). 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 Ashworth Street Surgery

Ashworth Street Surgery is situated Rochdale (with a branch surgery situated in the Norden area of Rochdale). At the time of this inspection we were informed 11,121 patients were registered with the practice. The population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There is a similar proportion of patients above 65 years of age (16%) than the practice average across England (16.53%). There is a higher proportion of patients under 18 years of age (17.5%) than the practice average across England (14.8%). 50 per cent of the 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) and in printed patient information. At the time of our inspection six partner GPs, one salaried GP, one locum GP and two registrar GPs were providing general medical services to patients registered at the practice. Five of the GPs are male and three are female. Four qualified doctors who are training to be GPs were also attached to the practice (two male and two female). The GPs are supported in providing clinical services by a nurse practitioner (female), two practice nurses (female) and three health care assistants (female). Clinical staff are supported by the 20 staff in the practice team. This team are led the practice manager.

Ashworth Street Surgery is accredited by the North Western Deanery of Postgraduate Medical Education as a GP Training Practice.

The practice contracts with NHS England to provide General Medical Services (GMS) to the patients registered with the practice.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Ashworth Street Surgery 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.

Detailed findings

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.

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 12 February 2015 and spent eight hours at the practice (including a visit to the branch surgery at Norden). We reviewed all areas that the practice operated, including the administrative areas. We received and reviewed 47 completed CQC comment cards, spoke with eight patients at the time of our inspection and four members of the practice's patient participation group (PPG) prior to and during 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, four of the other partner GPs, the nurse practitioner, one of the practice nurses, one of the health care assistants, the practice manager 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 Heywood, Middleton and Rochdale 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 the staff we spoke with told us that they were encouraged to participate in learning and to improve safety as much as possible. They also 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). Safety alerts were received electronically. These were reviewed by the nurse practitioner who then sent them to the appropriate staff for any relevant action to be taken.

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 Rochdale social services and the CCG when required and provided reports to them when requested to do so. We looked at three 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 and the nurse practitioner had received regularly updated enhanced (level 3) children's safeguarding training.

All the staff (clinical and non-clinical) we spoke with had a clear understanding of the principles of safeguarding children and vulnerable adults, could name the practice safeguarding leads and knew how to raise any safeguarding concerns.

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. 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.

Good

Are services safe?

Medicines Management

Systems were in place for the management, secure storage and prescribing of medicines within the practice. Management of medicines was the responsibility of the clinical staff at the practice. 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. The medicines management system ensured monitoring of the amount of medicines prescribed for the elderly and others with complex health needs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. Storage of medicines at the practice was secure and appropriate. This included vaccines that were required to be stored within a particular temperature range to ensure they were safe and effective. 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.

We also saw that practice staff were provided with equipment (for example 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 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 for safe disposal. We saw records that detailed when such waste was removed.

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 that ensured 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 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. We saw that this latter check was in place for all the clinicians at the practice.

Good

Are services safe?

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all clinical and non-clinical practice staff received annual basic life support training. 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.

We looked at records that demonstrated the practice had carried out risk assessments to identify all risks associated with their premises and that they were managing these risks.

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 NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (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 medicines prescribed, intra-uterine devices and asthma. 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, nurse practitioner and practice nurses had developed areas of interest and expertise (for example infection prevention, safeguarding, diabetes, dementia and asthma) and provided advice and support to colleagues in respect of these.

Feedback from patients we spoke with, or who provided written comments, were very positive in respect of the quality of the care and treatment provided by the staff team at the surgery.

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 mentoring by an experienced colleague and training relevant to their role. We saw that appraisals took place regularly. These were recorded and included consideration of the individual's development within their role.

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 (at the time of our visit) training and experience for four already qualified doctors to become GPs.

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. The practice also operated a system to ensure referrals were responded to in a timely way. Patients we spoke with, or received written comments from, told us 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.

Good

Are services effective?

(for example, treatment is effective)

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings 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. The practice also worked closely with the community matron to minimise the need for patients to attend the accident and emergency department or be admitted to hospital. 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 by 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 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. We were shown a number of examples where patients unable to make decisions in relation to their care and treatment were appropriately supported. 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.

Bi-annual health events were held (on Saturdays) to target patients who seldom attended the practice. They were provided with a series of health checks. Health trainers also provided a wide range of health promotion information during these events. These events were also attended and actively supported by the practice's very pro-active patient participation group (PPG) to help maximise patient engagement.

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. One of the nurse practitioner's roles was to contact hard to engage patients to encourage them to make convenient/flexible appointments to improve uptake of care and treatment.

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 47 completed CQC comment cards, spoke with eight patients on the day of inspection and four members of the practice's patient participation group (PPG) prior to and during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We were informed that patients were treated with respect, compassionately and as an individual.

There was a strong, visible, person-centred culture operating at the practice. All the staff we talked with placed emphasis on the importance of treating their patients with respect and as individuals. 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 maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an 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 January 2015 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. This reported that 83% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 84% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Information we received from patients indicated that practice staff listened to them and concerns about their health were taken seriously and acted upon. The 2015 GP patient survey reported that 94% of respondents said the last GP they saw or spoke to was good at listening to them. 90% 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 accessed (by telephone) and extended appointment times were provided to ensure this was effective. We were informed that a new telephone system had been ordered and this would incorporate a conference call facility that would improve consultations involving interpreters.

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 was provided on the carers notice board looked after by one of the staff who had also compiled a Carers register. The practice had also started to put an alert on patients records that Carers are identified easily.

Outstanding ☆

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. Home visits were provided to patients whose illness or disability meant they could not attend an appointment at the practice.

The GPs, nurse practitioner 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 Heywood, Middleton and Rochdale CCG and formed a part of the quality outcome monitoring. It also enabled the practice clinicians to check that all relevant patients had attended for a review of their medical conditions and a medication review.

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.

There was a strong, visible, person-centred culture. Staff were motivated and inspired to offer care that was responsive to people's needs, was kind and promoted people's dignity. Relationships between patients, those close to them, and staff were strong, responsive 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. In 2014 one of the GPs received a special memorial award at the Heywood, Middleton and Rochdale Clinical Commissioning Group (special thanks and recognition) Awards. Two other clinicians at the practice had also been nominated. Awards are made by local people and patients nominating local GP practice staff who are thought to deserve special thanks and recognition.

A primary prevention initiative was also in place aimed at providing specific health screening for the practice's younger Asian population to detect early signs of disease that had a higher prevalence in this group than the rest of the population. The initiative included staff going into local schools to promote the importance of such screening.

The practice is housed in a purpose built building. The practice has a reception area, patient waiting areas and a suite of consultation and treatment rooms on two floors. 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) and has a passenger lift.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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 47 completed CQC comment cards, spoke with eight patients on the day of inspection and four members of the practice's patient participation group (PPG) prior to and on the day of 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 January 2015 GP survey. 78% of the respondents found it easy to get through to the practice by phone. 90% were able to get an appointment to see or speak to someone the last time they tried and 89% said the last GP they saw or spoke to was good at giving them enough time. Also 97% said the last appointment they got was convenient and 87% described their experience of making an appointment as good. We were informed that the practice had recently purchased a new telephone system to improve patients telephone access.

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 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 extended hours on a Monday and Wednesday (6.30pm to 8pm) and provided Saturday morning appointments once per month (8am to 11am). Face to face and telephone appointments were available and the Practice provided an on line facility to make appointments the day before so that workers have the facility to book an appointment after work. On line appointments were also offered six weeks in advance. To improve patient access to services the practice opened a branch surgery at nearby Norden in 2012. An afternoon surgery is provided from Monday to Friday by two GPs. The branch surgery had been developed in response to the views of patients and the patient participation group (PPG). It has greatly improved access to the practice for older and less mobile patients who live in the Norden area of Rochdale. We visited the branch surgery on the day of our visit. This facility provided a reception area and two consulting rooms. Another Rochdale GP practice utilises the branch surgery in the mornings.

Consultations with the nurse practitioner, practice nurses and health care assistants 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. A system was in place for patients who required urgent appointments to be seen the same day..

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web-site. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

We looked at four complaints received in the last twelve months. In line with good practice all complaints or concerns were recorded and investigated. The complaints record detailed the nature of the complaint, the outcome of the investigation and how this was communicated to the person making the complaint. Discussion with staff and minutes of staff meetings demonstrated that learning from complaints was discussed at regular meetings to identify how improvements to the service could be made.

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 Middleton, Heywood and Rochdale 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. The practice manager chairs the monthly locality meeting with the CCG and has also planned, organised and delivered a level 3 training package for health care assistants in the borough. The GPs at the practice were also engaged in facilitating trainer group meetings and delivering clinical teaching sessions within and outside the practice.

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. 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 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 medicines prescribed, intra-uterine devices and asthma. 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.

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 12 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 responding to the changing needs of their patient population when required. 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.

Are services well-led?

Good

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

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 most recent practice patient survey and the January 2015 GP patient survey that reflected high levels of satisfaction with the care, treatment and services provided at Ashworth Street Surgery. Where issues were identified action had been taken to address them. The most recent 'Friends and family' survey results reflected that 37 out of 40 respondents would recommend the practice to others.

The practice had a very pro-active patient participation group (PPG) which has been in existence since October 2011. They provided a regular presence at the surgery to engage with their fellow patients to establish their views and promote various health initiatives in partnership with the practice team. The group had also actively supported the vaccination clinics for flu and shingles and the bi-annual health events that were held (on Saturdays) to target patients who seldom attended the practice. They had also been supporting another local practice in the development of their own PPG. We spoke with four members of the PPG prior to and during 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 valued. The practice website and PPG information board in the reception area 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 post graduate training and experience for 4 qualified doctors who are training to become GPs. 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.