Longford Street 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

We carried out an announced comprehensive inspection at Longford Street Medical Centre on 4 February 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they usually found it easy to make an appointment with a named GP and that there was 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 a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.

We saw several areas of outstanding practice including:

- Working with providers of secondary care within the practice for the benefit of local patients

The areas where the provider should make improvements are:

Summary of findings

- Improve the documentation and management of significant events and safety alerts.
- Introduce a clear whistleblowing policy and train staff in their responsibilities.
- Provide training in the Mental Capacity Act 2005.
- Clarify the practice vision and embed it amongst staff.
- Set up patient participation group (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. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health, although the need for additional training on the Mental Capacity Act and its implications was identified. Staff had received most training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed 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?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they usually found it easy to make an appointment with a named GP and that there was 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised, learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Management had a clear vision and strategy; some staff were not totally clear on this. Staff were clear about their responsibilities in relation to ensuring high standards of patient care. 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 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. There was no patient participation group (PPG), however plans were in place to introduce one as soon as possible. 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 is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and outreach clinics.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of 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. The practice was proactive in offering online services as well as

Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. The practice had formed a consortium with other practices in the area in order to be able to offer services seven days a week.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, asylum seekers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and patients are referred to a memory assessment clinic when appropriate. One GP at the practice took the lead for issues around mental health and had considerable experience in this field.

Summary of findings

What people who use the service say

We received 29 completed CQC patient comment cards and spoke with ten patients at the time of our inspection visit. We spoke with mothers and fathers with young children, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

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 showed that the practice was average or higher than average amongst practices in the area:

81% of respondents found the receptionists at the practice helpful

83% of respondents said the last appointment they got was convenient

83% of respondents said the last GP they saw or spoke to was good at listening to them

72% of respondents described their overall experience of this surgery as good

Areas for improvement

Action the service SHOULD take to improve

Improve the documentation and management of significant events and safety alerts.

Introduce a clear whistleblowing policy and train staff in their responsibilities.

Provide further training in the Mental Capacity Act 2005.

Clarify the practice vision and embed it amongst staff.

Set up patient participation group (PPG).

Outstanding practice

Working with providers of secondary care within the practice for the benefit of local patients.

Longford Street 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 manager).

Background to Longford Street Medical Centre

Longford Street Medical Centre is situated close to Heywood town centre and approximately equidistant between Rochdale and Bury. At the time of this inspection we were informed 9,812 patients were registered with the practice.

The practice consisted of five GPs (four partners and one salaried GP, two female and three male). These GPs are providing general medical services to registered patients at the practice under a general medical services (GMS) contract. The GPs are supported in providing clinical services by two practice nurses (female), two locum nurses and two health care assistants (HCA) (female). Clinical staff are supported by the practice manager and her team who are responsible for the general administration, reception and organisation of systems within the practice.

The practice is part of the Heywood health hub which is a pilot involving the GP practices in the area who provide routine out of hours appointments seven days a week.

Out of hours service is provided by Bury and Rochdale Doctors on call (BARDOC).

The CQC intelligent monitoring placed the practice in band 5. 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.

Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

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 4th February 2015. During our visit we spoke with four GPs, two nurses, one HCA, the practice manager and reception staff. We also spoke with a dispenser from the attached pharmacy, a visiting Consultant Ophthalmologist running an outreach clinic and patients who used the service.

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. The Practice Manager and GPs recognised that they wished to improve the manner in which significant events were managed and documented. We looked at minutes of team meetings and confirmed that some improvements around the recording and review of these events were needed. We noted that clinical and non-clinical staff were able to describe a number of significant events and how they had been investigated, there was a lack of understanding about which events required referral to other agencies such as the CCG and the CQC.

The practice had a system for dealing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and sent to the clinical staff for their information. One of the practice nurses had responsibility for managing these alerts and ensuring that all had been reviewed, progressed and finalised. The results were returned to the Practice Manager for collation, we saw email history which evidenced that this was taking place.

Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Significant events and changes to practice were discussed with practice staff. Action was taken to reduce the risk of recurrence in the future. The GP completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. The Practice Manager told us that regular informal clinical meetings were held and that full staff meetings always took place monthly and the practice was closed for these events. These meetings were also the time that staff training and performance meetings took place. We looked at the minutes of these meetings and saw that they were well attended and clearly documented.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3 for children) safeguarding training for those with key safeguarding roles. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Some staff were not aware of how to raise issues about staff within the practice via the whistleblowing procedure. We noted that the practice did not have a whistleblowing policy for staff to refer to if they wished to raise concerns without informing practice management. The Practice Manager told us that this would be rectified and that a policy would be introduced and staff trained in its content with the policy being made available on the practice computer system, as all other practice polices were.

Practice nurses and HCAs were available to chaperone patients who requested this service and information about this service was available in the waiting area and posted on consulting room doors. Staff had been trained in how to chaperone. When we spoke to nurses and HCAs they told us that they were confident in performing a role as a chaperone, and told us that the GPs would always explain in full to the patient what they were doing and why.

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 practice nurses. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the

practice internal systems. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. Patients who had any history of drug abuse or who were suspected of such were flagged on the clinical system and prescribing was closely monitored. A system was in place for monitoring any prescriptions that had not been collected. Prescription security was well managed by the practice. Any medication errors were treated as significant events. The practice shared a building with a pharmacy, this made it easy for patients to collect their prescriptions and any confusion or questions relating to prescribed medicines could be quickly dealt with.

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 saw that there were four purpose built fridges all kept in locked rooms, equipped with locks and devices for monitoring maximum and minimum temperatures. The fridges were not hard wired and one of the fridges had its power source located where it might be inadvertently switched off. The Practice Manager told us that this issue would be rectified. We saw that systems were in place to check temperatures of the fridges and to effectively manage the stock contained within them.

A cold chain policy was in place to ensure that the drugs requiring storage at particular temperatures were dealt with appropriately. Staff we spoke to told us they were clear on the policy and how to implement it.

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 and infection control

Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our inspection and patients we spoke to confirmed that this was always the case. A system was in place for managing infection prevention and control. We saw that a recent audit relating to infection control had been completed by the Practice Manager and the lead for infection control.

We 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. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and there was a documented protocol in place.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques.

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 before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use; however these were not fixed to walls and were not all positioned out of the reach of small children.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing (PAT) and calibration of equipment such as fridges and other electrical devices. Documentation evidenced that equipment in use was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not. We looked at medical equipment used at the practice in readiness for use and found that it was all within the manufacturers' recommended use by date.

Staffing and recruitment

The provider recruitment policy was in place and up to date. We looked at two staff files and saw all of the employment checks that were required to be carried out had been completed. The GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses who carried out chaperoning

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Are services safe?

duties also had DBS checks completed. Where relevant, the practice also made checks that members of staff were registered with their professional body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. Any sickness was closely monitored and return to work interviews were routinely completed. Support was given to staff where possible when they required it with issues related to sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy this and all other practice policies were available to all staff at any time via a shared area on the practice computers.

Arrangements to deal with emergencies and major incidents

Basic life support training was done every year with all staff and this included using a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and fire alarm tests were completed on a weekly basis, one such test took place during our inspection.

We saw appropriate emergency equipment and emergency drugs were available and staff knew where these could be located. We saw that emergency drugs and equipment were regularly checked by the practice nurses to ensure it was operative and within the manufacturer's recommended usage date.

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. Staff we spoke with were aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and HCAs. The practice utilised a system called the 'proactive care programme' which used a scoring system to identify the patients most at risk. 315 patients were currently on the register, 267 of whom had care plans in place; we saw that these were regularly reviewed. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance.

The practice had a documented system for reviewing patients with specific conditions. The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included Asthma, Heart Disease, Kidney Disease, COPD, Dementia, Epilepsy, Hypertension, Mental Health, Peripheral Arterial Disease, Rheumatoid Arthritis, Stroke and Thyroid. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. Reception staff were able to use a colour coded chart to ensure that appropriate appointment lengths were booked depending on the conditions the patient was diagnosed with. We saw that the practice ensured that checks on patients' blood were completed before the reviews to ensure the GP had as much information available as possible. The practice maintained a system where patients were sent up to three recall letters to remind them about reviews; if these were not answered then staff would telephone patients to remind them.

Care Plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and heart failure. We reviewed a sample of these care plans and saw they were detailed and had been used by other health professionals to make informed decisions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all clinical staff to continually review and discuss new best practice guidelines.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff meetings and local forums where appropriate.

The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of GPs in the NHS. It was intended to improve the quality of general practice and the QOF rewards GPs for implementing "good practice" in their surgeries. This practice had achieved high scores for QOF over recent years which demonstrated they provided good effective care to patients. QOF information indicated the percentage of patients aged 65 and older who had received a seasonal flu vaccination was higher than the national average. QOF information also indicated that patients with long term health conditions received care and treatment as expected and above the national average including for example patients with diabetes had regular screening and monitoring, clinical risk groups (at risk due to long term conditions) had good uptake rates for seasonal flu vaccinations.

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. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice completed clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG audits. One example was provided by one of the practice nurses, where patients at risk of developing diabetes were reviewed and any assessed as higher risk were called in for a consultation. To date this year, 57 such patients had been identified and had been written to using a bespoke letter to reduce anxiety. As a result of the audit two patients had

Good

Are services effective?

(for example, treatment is effective)

been identified as having developed the condition, others who had not had been provided with advice on how to help avoid developing diabetes. The audit was due for review and plans were in place to continue the audit as a way of continually identifying at risk patients.

We saw no evidence of documented peer review within the practice and we discussed this with the Practice Manager and two of the GPs. They confirmed that peer review was completed on a regular basis in clinical meeting and by ad hoc discussions; they recognised the need to document reviews and told us that this would be introduced.

The GPs, nurses and HCAs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as endocrine medicines (treatment of diseases related to hormones), cardiology. palliative care, spirometry and safeguarding patients. They provided advice and support to colleagues in respect of their individual area.

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.

The practice rented some of their consulting room space to secondary care services, for example ophthalmology, retinopathy and counselling services. This provided benefit to the local population who did not have to travel long distances to reach these services. We spoke to a visiting Consultant Ophthalmologist who specialised in eye conditions; he described some additional benefits for local patients. Patients needing their eyes examining often required treatment to dilate their pupils in order to make an effective examination. This meant that they were unable to drive a car, the fact that the service was provided locally meant they were able to walk to the practice to have their consultation as opposed to having to rely of friends or family to drive them or use public transport to reach a hospital several miles away.

Effective staffing

All the staff we spoke to at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice. We spoke to one member of staff who had been a receptionist and due to their own ambition and support from the practice they had become a successful HCA. The GPs told us they led in specialist clinical areas such as respiratory disease, mental health, dermatology and cardiology.

Most reception staff were long serving and they knew the regular patients well. There was an induction process for any new staff which covered areas such as the introduction to policies and procedures, confidentiality and health and safety issues.

The GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the general medical council (GMC), that they were up to date and fit to practice. The GPs we spoke to told us they undertook regular clinical appraisals.

All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients. The practice had dedicated members of staff for updating information on systems and scanning documents in.

Information sharing

GPs met regularly with the practice nurses and the Practice Manager. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. Regular meetings involving all team members keep staff up

Good

Are services effective?

(for example, treatment is effective)

to date with current information around enhanced services, requirements in the community and local families or children at risk. A pharmacy was co-located within the building and staff at the pharmacy told us of an effective working relationship and excellent communication with staff at the practice.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Manager regularly attended area Practice Manager meetings to share information about their role and maintain their professional knowledge.

There was an informative practice website with information for patients including signposting, what clinics were available and prescription information. There was no patient participation group established at the practice and the Practice Manager told us that this was one of the priorities for the coming months.

Consent to care and treatment

Patients we spoke with told us that they were spoken to 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. The practice computer system identified those patients who were registered as carers so that clinicians were aware that consent to treatment may be an issue for consideration. A consent policy was in place at the practice and staff were able to access this via a shared area on the practice computer systems.

GPs and clinicians had not received formal training in the Mental Capacity Act however we saw evidence from GPs that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary. We looked a documented example of where one of the GPs had been involved in making a best interest decision for a patient, we saw appropriate people had been consulted and an auditable document trail had been completed. We spoke to the GPs and Practice Manager about the lack of formal training in the Mental Capacity Act and its implications; we were told that training for staff would be completed as soon as possible.

The 2014 national GP patient survey indicated 80% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 75% said the last GP they saw or spoke to was good at involving them in decision making and 93% had confidence and trust in the last GP they saw or spoke to. These percentages were on par or above the average for the area.

Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse or the HCA. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate. Where there were issues identified that required more detailed consultation, then patients were referred to one of the GPs.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. We saw that the annual flu vaccination campaign had been well advertised and was near completion at the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to nine patients in person and received feedback from 29 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the GPs. Several people told us that the GPs would often 'go the extra mile' for example ringing patients later in the day after a consultation to see how they were feeling.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use in most rooms during physical and intimate examinations and a chaperone service was offered (some rooms were small and curtains were impractical). Staff had received training on how to be an effective chaperone.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in information security, safeguarding children and adults and information governance. We also noted that there were practice policies to cover all these areas which staff could access via a shared area on the practice computers.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 78% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 89% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were similar or higher than those for most other practices in the area.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

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

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2014 GP patient survey reported that 75% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 85% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments. These percentages were similar or higher than most other practices in the area.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and so were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer or a vulnerable. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

One of the GPS took the lead for palliative care. The practice maintained a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings minutes. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

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 met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, practice manager meetings, primary health care team meetings and meetings with community matrons and district nurses.

Patients were able to access appointments with a named doctor where possible. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP, many preferred to wait for a later appointment in order to see that GP. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered 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 regular checks on how it was responding to patients' medical needs. This 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. A documented system was in place to ensure that people who required regular reviews were contacted and a suitably long appointment was scheduled in order to meet their individual needs. Reception staff used a colour coded chart to help them gauge the length of appointment required.

Longford Street Medical Centre had a reception area and sufficient consultation and treatment rooms. There were also facilities to support the administrative needs of the practice (including reception offices, practice manager's office and meeting rooms). The building was easily accessible to patients including those with a disability a lift which could accommodate wheelchairs had been installed, so that staff or patients requiring access to the first floor could do so.

The practice had recognised that it could improve the way it listens to its patients by setting up a PPG; the Practice Manager told us that this was a priority. The practice used a suggestion box and word of mouth to listen to what patients thought. In January 2015 the practice had undertaken a patient survey in response to concerns about access to appointments; the survey provided the information required for the changes to the appointment system to be introduced. Patients we spoke to told us that they had noticed an improvement in accessing appointments. The Practice Manager told us that they intended to continue to survey patients for their views on this and other aspects of the service provided.

Tackling inequity and promoting equality

The practice had taken steps 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 service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

We saw that a number of asylum seekers were registered at the practice and seen by clinicians so as to meet their needs. We were told that the numbers of asylum seekers registered at the practice had increased several fold over the last year. The practice provided information for people whose first language was not English as well as interpreter services. Asylum seekers details were recorded on a separate register and flagged on the clinical systems. There

Good

Are services responsive to people's needs?

(for example, to feedback?)

were good communication links with the local homeless and vulnerable people service, who were able to provide information on the medical requirements of this group of people.

Access to the service

There were some negative comments about being able to access the services at the practice; however the practice had recently changed the system for accessing appointments, which had seen some success. We looked at the results of the 2014 GP survey 81% of respondents found the receptionists at the practice helpful, 83% of respondents said the last appointment they got was convenient and 47% of respondents described their experience of making an appointment as good. These percentages were average or below when compared with other practices in the area.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday 8.00am to 6.00pm. Extended hours were operated on Wednesdays from 7.00am until 8.00am to provide service for people who could not generally attend during office hours. The practice was also a member of the Heywood health hub which provided extended hours appointments seven days a week by making GP appointments available on a rota agreed between practices in the area. There were 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

GP appointments were provided in ten minute time slots and were pre bookable up to four weeks in advance; longer appointments were available for patients with more than one issue for discussion. Urgent appointment slots were kept available throughout the day with one of the GPs always 'on call' during surgery hours. Telephone consultations were used when appropriate. Two female and three male GPs were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The Practice Manager told us that they were constantly reviewing patient demand and responding to it by altering the patients booking system to ensure it was always effective.

The practice used an electronic messaging system to aid communication between administration staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service. The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where the GP used the electronic messaging system linked to a recorded GP voice recording to prompt reception staff to create an appropriate appointment based on patient choice.

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. The Practice Manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system both within a practice complaints and comments leaflet as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review and identify any trends. We saw that the eleven complaints which were recorded in 2014 had been reviewed in January 2015, these complaints were categorised and studied so that any learning and potential improvements could be identified.

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 clear leadership structure at the practice and staff were aware of how the management structure operated and their responsibilities. Staff we spoke to were unable to describe the practice vision but knew they formed part of a team which was aiming to provide the best care possible. We spoke to the Practice Manager and the GPs about the vision and values of the practice; they told us that they had become part of the ethos of providing the highest standards of care possible. We asked them about how vision and values were formalised with staff so that they became part of their overall personal objectives. We were told that whilst not formally documented, they already formed part of team goal of continuous improvement. The Practice Manager told us that focus would be given to making the practice vision more visible to staff and patients and that individual objectives to achieve the practice vision would for part of the appraisal regime in future.

We saw that the practice had a documented statement of purpose and included in their aims and objectives 'To provide the best possible quality service to our patients within a confidential and safe environment by working together. To involve our patients in decisions regarding their treatment. To promote good health and well being to our patients through education and information. To ensure that all members of the team have the right skills and training to carry out their duties competently. To provide a high quality of care within a primary care setting.'

Governance arrangements

The practice held regular documented meetings for clinicians and management. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

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 level of the average for the area (96%). We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. We saw evidence that showed the GP and practice manager met with the (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 had a system in place for clinical audit cycles; we saw several examples of these having taken place. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits.

Leadership, openness and transparency

Staff told us that they felt valued and well supported and knew who to go to in the practice with any concerns. The reception team had worked together for many years and had been afforded opportunities to develop both within their role and into clinical roles. The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw staff undertook annual appraisals and these were completed in a timely manner. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example bullying and harassment and equal opportunities, which were in place to support staff. We were shown the staff induction handbook that was available to all staff which included sections on equality and confidentiality. Staff we spoke with knew where to find these policies if they required them for review.

We were told that support for learning, development was very good. Documented peer review was not evident but the GPs told us that this took place informally. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the practice manager. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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 its patients, the public and staff

The practice had gathered feedback from patients through comment cards and complaints received. We looked at the results of the 2014 GP patient survey it reflected high levels of satisfaction with the care, treatment and services provided at Longford Street Medical Practice.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development. Staff we spoke to had not been asked to complete any staff satisfaction surveys, the Practice Manager told us that this was an initiative that they were introducing as part of their listening culture.

The practice undertook reviews to ensure quality, including reviews of abdomen aortic aneurism (AAA), bowel screening, breast screening, breast feeding, cancer diagnosis and death analysis.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with clinical staff during meetings to ensure outcomes for patients improved. We noted that the practice was very open and transparent in sharing any errors and issues of concern. For example they had identified a member of staff who had been breaching confidentiality, they raised it as an issue of gross misconduct, notified appropriate authorities, recorded the matter as a significant event and the person was dismissed.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. All clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.