Dr F J Ahmad

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Dr F J Ahmad was inspected on 26 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 requires improvement in relation to being safe and good in respect of being effective, caring, responsive and well-led.

Our key findings were as follows:

The practice has a system in place for reporting, recording and monitoring significant events. Significant incidents and events are used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice.

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

Information we received from patients reflected that practice staff interact with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.

Patients spoke positively in respect of accessing services at the practice. A system is in place for patients who require urgent appointments to be seen the same day.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Take action to ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection.

Ensure that patients, staff and others accessing the premises are protected against the risks associated with fire.

Improve the system of staff recruitment to ensure that patients are protected by operating effective recruitment

Summary of findings

and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed or are engaged in a role where such checks are required.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. The practice team learnt from such incidents and changed their systems and practices accordingly. Not all risks to patients who used services were assessed because systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe. In particular the practice must make improvements in respect of infection control, staff recruitment records and fire safety.

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. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received 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 Englandand the localClinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they 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

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

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 responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and 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 active. 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. The practice had established and developed strong links with the integrated care programme in Rochdale and in particular had frequent contact with the local community matron to minimise the need for patients to go to the local A+E department or be admitted to hospital. This was particularly helpful for elderly patients and those with complex health conditions who were at higher risk of being admitted to hospital.

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. The practice had established and developed strong links with the integrated care programme in Rochdale and in particular had frequent contact with the local community matron to minimise the need for patients to go to the local A+E department or be admitted to hospital. This was particularly helpful for patients with complex health conditions who were at higher risk of being admitted to hospital.

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, 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. 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 school nurses.

Summary of findings

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 a full range of health promotion and screening that reflects the needs for this age group. To improve patient access a late surgery and Saturday morning surgery was provided. This was particularly helpful to patients who worked or attended further education training. Patients were also enabled to access (along with other practices in the area) medical advice by attending a medically led walk in centre and a local practice that provides access to GP appointments 7 days per 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, travellers 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. The practice had established links with a local gay and lesbian group as well as other voluntary and third sector groups. The purpose of these links are to encourage and maximise access to primary medical care and treatment particularly for those patient groups who may find it difficult (for various reasons) to readily engage with such services. 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). People experiencing poor mental health received an annual physical health check. 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.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. 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.	

Summary of findings

What people who use the service say

We received 33 completed CQC comment cards and spoke with seven patients on the day of inspection and four members of the practice's patient participation group (PPG) prior to our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed CQC 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 said 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 fairly regularly and that their views were listened to, respected and acted upon to improve the experience of patients.

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;

69% of respondents find it easy to get through to this surgery by phone. (Local CCG average: 63%).

87% of respondents find the receptionists at this surgery helpful. (Local CCG average: 84%).

80% of respondents were able to get an appointment to see or speak to someone the last time they tried (Local CCG average: 80%).

What this practice could improve;

60% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. (Local CCG average: 82%).

74% of respondents had confidence and trust in the last GP they saw or spoke to (Local CCG average: 95%).

54% of respondents are satisfied with the surgery's opening hours. (Local CCG average: 72%).

433 surveys sent out. 72 surveys back. 17% completion rate.

Areas for improvement

Action the service MUST take to improve

The provider must take action to ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection.

The provider must ensure that patients, staff and others accessing the premises are protected against the risks associated with fire.

The provider must Improve the system of staff recruitment to ensure that patients are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed or are engaged in a role where such checks are required.

Dr F J Ahmad

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Inspector and two specialist advisors (a GP and a practice manager).

Background to Dr F J Ahmad

The practice of Dr F J Ahmad is situated in the Langley area of Middleton. At the time of this inspection we were informed 2,300 patients were registered with the practice. The population experiences much higher levels of income deprivation than the practice average across England. There is a lower proportion of patients above 65 years of age (10.8%) than the practice average across England (16.7%). There is a higher proportion of patients under 18 years of age (17.5%) than the practice average across England (14.8%). 59.9 per cent of the patients have a longstanding medical condition compared to the practice average across England of 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 4 long term locum GPs (2 male and 2 female) were providing primary medical services to patients registered at the practice. The principal doctor (female) who is also the registered provider is currently conducting 2 clinical sessions a week in relation to drug dependency and cytology and 1 session per week in relation to administration. The GPs are supported in providing clinical services by a practice nurse (female). Clinical staff are supported by the staff in the practice team. This team is led by the practice manager.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider. The practice website provides patients with details of how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times. Patients registered at the practice are also enabled to access medical advice by attending a medically led walk in centre and a local GP practice that provides access to appointments 7 days per week.

The provider informed us that they have purchased a property adjacent to the existing practice. We have been informed plans have been submitted for the purchased property to house the existing practice and thereby improve the facilities and develop the services currently provided. We understand the provider is consulting with NHS England and NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) regarding this proposed development.

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.

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 26 February 2015 and spent eight hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received and reviewed 33 completed CQC comment cards, spoke with 7 patients at the time of our inspection and four members of the practice's patient participation group (PPG) prior to our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with the principal doctor who is the registered manager, 2 of the locum GPs, the practice nurse, the practice manager and 2 members of the practice team who were working at the time of our visit.

Requires improvement

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 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. Discussions with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. Learning was based on a thorough analysis and investigation of things that go wrong. All staff were encouraged to participate in learning and to improve safety as much as possible. Opportunities to learn from external safety events were identified. We spoke with clinical and non-clinical staff. They told us that the culture at the practice was fair and open and that they were encouraged to report incidents and mistakes and were supported when they did so. The learning from significant events was discussed at the monthly practice 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). These were communicated to the GPs and practice nurse and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. We were informed that one of the GPs took the lead on safeguarding children and vulnerable adults. 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 highlighted to the GPs 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. Staff training records did not clearly demonstrate when some clinical and non-clinical staff had last been provided with safeguarding training in respect of vulnerable children and adults. We saw evidence that one of the GPs had received enhanced (level 3) children's safeguarding training and arrangements had been made for all other clinicians to access that training in April 2015.We also saw evidence that safeguarding training had been arranged for all other practice staff in March 2015.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. No issues in respect of chaperoning were raised by patients we spoke with or received information from. However it was noted that none of the non-clinical staff who carried out chaperoning duties had a Disclosure and Barring Service (DBS) check. Whilst it is acknowledged non-clinical staff at the practice had worked there for many years those members of staff who undertake a chaperone role should have had a DBS check. No risk assessment had been conducted to assess the chaperoning responsibilities and activities of non-clinical staff to determine if they were eligible for a DBS check and to what level. Where the decision had been made not to undertake a DBS check on staff, the practice must be able to give a clear rationale as to why.

Requires improvement

Are services safe?

Medicines Management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of the clinical staff at the practice. 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. It was established practice to monitor the amount of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained.

Cleanliness & Infection Control

We looked around the practice during our visit. Systems were in place for to ensure 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. The practice manager and practice nurse 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. We saw evidence that recent checks had been undertaken to make sure measures taken to prevent the spread of potential infections were periodically risk assessed. This is important to ensure their continued effectiveness and minimise the risks associated with potential infections. A risk assessment had been undertaken in respect of the risk of legionella in 2012. The assessment detailed the need to implement a monitoring programme to minimise the risk of legionella which is a germ found in the environment which can contaminate water systems in buildings. No evidence was shown to us to demonstrate that the actions required in the monitoring programme had been completed. The provider must take action to ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection.

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.

We looked at the three consulting/treatment rooms. These rooms were clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste was stored safely and securely in specially designated bags before being removed by a specialist contractor. 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 it was recorded when any items were repaired or replaced. We saw that all of the equipment had been regularly 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 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 had recently reviewed their staff mix, numbers and configuration 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 provider.

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 for all clinicians to assess the person's suitability to work with

potentially vulnerable people. None of the non-clinical staff who carried out chaperoning duties had a Disclosure and Barring Service (DBS) check. Whilst it is acknowledged non-clinical staff at the practice had worked there for many years those members of staff who undertake a chaperone role should have had a DBS check. No risk assessment had been conducted to assess the chaperoning responsibilities and activities of non-clinical staff to determine if they were eligible for a DBS check and to what level. Where the decision had been made not to undertake out a DBS check on staff, the practice must be able to give a clear rationale as to why. The provider must improve the system of staff recruitment to ensure that patients are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed or are engaged in a role where such checks are required.

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 practice staff received annual basic life support training. Non-clinical staff received such training every three years. We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice. The plan had been developed in conjunction with the CCG and identified a local 'buddy' practice that would provide support in the event of an emergency or major incident occurring.

The practice is housed in two extended semidetached houses. No information was displayed to inform patients, staff or visitors to the practice what to do in the event of a fire breaking out. There were no records of planned or practised fire safety drills or of staff being provided with fire safety training. We were informed by the provider that a fire safety risk assessment had not been carried out in respect of the practice premises. The provider must ensure that patients, staff and others accessing the premises are protected against the risks associated with fire. We note the provider informed us at the end of our visit that these issues would be addressed immediately.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients care, treatment and support achieved good outcomes and was based on the best available evidence. Clinical practice was based on 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 were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by clinicians.

Discussion with two of the GPs and the practice nurse and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported.

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 sought 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. We saw three recent examples of these at the practice relating to respiratory illnesses, calcium and vitamin D therapy and stroke and atrial fibrillation. All had been completed.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. Practice meeting minutes we looked at provided details of how the actions to make improvements taken were monitored over time to ensure they were embedded and effective.

The GPs and practice nurse had developed areas of expertise and took 'the lead' in a range of clinical areas such as infection prevention and control and safeguarding children and vulnerable adults. 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 very positive and complimentary in respect of the quality of the care, treatment and support provided by the practice team. There was no evidence of discrimination of any sort in relation to the provision of care, treatment or support.

Effective staffing

The practice team comprised of clinical and non-clinical staff were very well established and there was a very low turnover of staff.

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. We saw that yearly staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff we spoke with said they being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. Both the GP's had undergone recent clinical appraisals. The practice nurse was supported to attend updates to training that enabled them to maintain and enhance their professional skills.

Working with colleagues and other services

Systems were in place to ensure 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. All referrals were frequently tracked by one of the administrative staff to ensure patients could access appointments effectively. Patients we spoke with, or

Good

Are services effective?

(for example, treatment is effective)

received written comments from, said that if 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.

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 with McMillan nurses to plan and co-ordinate the care of patients coming to the end of their life. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hour's service. In particular the practice provided detailed clinical information to the out of hour's service about patients with complex healthcare needs. Also all patient contacts with the out of hour's provider were reviewed by the GP the next working day. The practice had established and developed strong links with the integrated care programme in Rochdale and in particular had frequent contact with the local community matron to minimise the need for patients to go to the local A+E department or be admitted to hospital. This was particularly helpful for elderly patients and those with complex health conditions who were at higher risk of being admitted to hospital.

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

Information sharing

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

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The January 2015 GP patient survey reflected that 60% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 69% said the last GP they saw or spoke to was good at explaining tests and treatments and 79% say the last nurse they saw or spoke to was good at explaining tests and treatments.

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. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Where people lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with legislation. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and of supporting those who did not have the mental capacity to make a decision in relation to their care and treatment.

All clinical staff demonstrated a clear understanding of the Gillick competencies. (These help clinicians to identify children under 16 who have the capacity to consent to medical examination and treatment).

Health promotion and prevention

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to quickly 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. The practice nurses conducted the initial health screening assessments and made referrals to the GP for further assessment as appropriate.

A wide range of health promotion information was available and accessible to patients particularly in the patient waiting area of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and 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 and influenza vaccinations were provided.

Good

Are services effective?

(for example, treatment is effective)

The provision of health promotion advice was an integral part of each consultation between clinician and patient. Patients were also enabled to access appropriate health assessments and checks.

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

Patients with long term sickness 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 33 completed CQC comment cards, spoke with 7 patients and also spoke with 4 members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs. Feedback we received from patients and those who were close to them was without exception positive about the way they were treated by staff. Patients told us that staff went the extra mile. They cited a number of examples where staff (clinical and non-clinical) went out of their way to provide re-assurance and support to them and their family. They felt that because the patient group was relatively small staff knew them well and appreciated their concerns more. Information we received from patients reflected that practice staff interacted with them positively and empathetically. They told us that staff at the practice treated them with respect, politely manner and as an individual.

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

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 individual consultation rooms. 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 patient's privacy and dignity was not respected they would be confident to raise the issue with the practice manager. We saw no barriers to patients accessing care and treatment at the practice. Practice staff sought to work with patients who had at times presented with behaviour that was challenging. The approach adopted at the practice was to seek to resolve the issue and keep engaging with the individual patient.

Care planning and involvement in decisions about care and treatment

The January 2015 GP patient survey reflected that 60% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. 69% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon.

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

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

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers.

A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area.

The lead GP worked very closely with the local substance misuse practitioner to provide drug rehabilitation and support group that met at the practice on a monthly basis. The practice, which encompassed a highly deprived area of Rochdale had developed strong links with local voluntary and third sector groups particularly in relation to mental health to maximise the support provided to patients and their carer's. A counselling support service was also available to provide emotional support to patients following referral by the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The GPs and practice nurse 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. Where patients did not attend such appointments the GP who is the registered provider or the practice nurse personally contacted each patient to encourage them to attend and discuss any concerns they may have.

We saw that the practice carried out 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 outcomes framework monitoring (QOF). It also assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews.

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

The practice has a reception area, a patient waiting area and three consultation and treatment rooms. There are also facilities to support the administrative needs of the practice.

Tackling inequity and promoting equality

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

The practice had established links with a local gay and lesbian group as well as other voluntary and third sector groups. The purpose of these links was to encourage and maximise access to primary medical care and treatment particularly for those patient groups who may find it difficult (for various reasons) to readily engage with such services.

Access to the service

We received 33 completed CQC comment cards, spoke with 7 patients and also spoke with 4 members of the practice's patient participation group (PPG). We spoke with patients from various age groups and with people who had different health care needs. Patients we spoke with or received comments from spoke positively in respect of being able to

Good

Are services responsive to people's needs?

(for example, to feedback?)

access the service. We also looked at the results of the January 2015 GP survey. 64% of the respondents found it easy to get through to the practice by phone. 80% were able to get an appointment to see or speak to someone the last time they tried and 85% said the last GP they saw or spoke to was good at giving them enough time. 87% of respondents found the receptionists at the practice helpful. Also 81% said the last appointment they got was convenient and 66% described their experience of making an appointment as good.

The opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas and were also contained on the practice website and in the practice information leaflet readily available to patients in the reception area. To improve patient access to a late surgery and Saturday morning surgery was provided. This was particularly helpful to patients who work. Patients were also enabled to access (along with other practices in the area) medical advice by attending a medically led walk in centre and a local practice that provides access to GP appointments 7 days per week.

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. Information on the out-of-hours service was provided to patients.

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. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at three formal 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.

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 GPs and the practice team. The GP who is the registered provider and the practice manager 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 one that was open and fair. Discussion with members of the practice team and patients generally demonstrated this perception of the practice was widely shared.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to challenge existing arrangements and improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve 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 in line with national standards. 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 sought 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. We saw three recent examples of these at the practice relating to respiratory illnesses, calcium and vitamin D therapy and stroke and atrial fibrillation. All had been completed. All identified dates in the future when they had been or were due to be reviewed.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. For example the practice nurse led on infection prevention and control, and the GP led on safeguarding. We spoke with six 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 that practice 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 during the regular informal discussions that took place.

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

Practice seeks and acts on feedback from its patients, the 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 January 2015 GP patient survey and the last survey conducted by the practice in January 2014. Both surveys reflected satisfaction with the care, treatment and services provided at the practice. However where issues were identified action had been taken to address them.

The practice had an active patient participation group (PPG). We spoke with four members of the PPG prior to our visit to the practice. They told us that when issues were identified the PPG was actively consulted to develop plans to address them. They felt their views and contributions were respected and valued. Patients were being encouraged to actively comment on the services available and the planned developments.

The practice had gathered feedback from staff through staff meetings and informal discussions. Staff 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. Staff told us that

Are services well-led?

Good

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

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 regular training and appraisal. We saw that staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of infection. This was in breach of regulation 12 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** A risk assessment had been undertaken in respect of the risk of legionella in 2012. The assessment detailed the need to implement a monitoring programme to minimise the risk of legionella which is a germ found in the environment which can contaminate water systems in buildings. No evidence was shown to us to demonstrate that the actions required in the monitoring programme had been completed. The provider must take action to ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infection. . Regulation 12 (2)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of fire at the registered location. This was in breach of regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:
No information was displayed to inform patients, staff or visitors to the practice what to do in the event of a fire breaking out. There were no records of planned or practised fire safety drills or of staff being provided with fire safety training. We were informed by the provider that a fire safety risk assessment had not been carried out in respect of the practice premises. The provider must ensure that patients, staff and others accessing the premises are protected against the risks associated with fire.

Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against risk related to staff employed at the registered location. This was in breach of regulation 21 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** The provider must Improve the system of staff recruitment to ensure that patients are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed or are engaged in a role where such checks are required. None of the non-clinical staff who carried out chaperoning duties had a Disclosure and Barring Service (DBS) check. Whilst it is acknowledged non-clinical staff at the practice had worked there for many years those members of staff who undertake a chaperone role should have had a DBS check. No risk assessment had been conducted to assess the chaperoning responsibilities and activities of non-clinical staff to determine if they were eligible for a DBS check and to what level. Where the decision had been made not to undertake out a DBS check on staff, the practice must be able to give a clear rationale as to why.

This section is primarily information for the provider

Requirement notices

Regulation 19 (1)(3)(a).