

# Heady Hill Surgery

## Quality Report

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Date of inspection visit: 12 February 2015

Date of publication: 16/04/2015

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

## Ratings

### Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

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 Heady Hill Surgery on 12 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and well-led services. The practice also provided an outstanding responsive service.

Our key findings across all the areas we inspected 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.
- 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.
- The practice were continually reviewing access for patients based on feedback about their appointment system. Most patients said they found it easy to make an appointment with a named GP and that there was continuity of care.
- 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, which it acted on.
- The practice were able to evidence that they were continually monitoring and reviewing the quality of the service provided through clinical audits and information based on feedback from patients.
- The lead GP of the practice had set up a pilot service called the Heywood Health Hub (HHH) following a successful bid for funding. HHH is a central hub of medical and nursing staff (employed by Bardoc) and

# Summary of findings

provides extended hours of access, seven days a week, for all patients registered with a Heywood GP. We saw evidence that this service created increased access for patients of this and other practices.

We saw some areas of outstanding practice:

- The practice was pro-active in their safeguarding of children. All children under the age of five years were offered a full health check to identify any underlying potential illness or safeguarding issue. The practice nurse provided an example where early intervention had provided a positive impact for the patient.
- The practice had signed up to the electronic prescribing service and were rated the highest achieving practice in the Clinical Commissioning Group (CCG) with 90% of patients now receiving their prescriptions electronically. Patients were spoke with and evidence from feedback that the practice had obtained provided positive outcomes for patients in relation to this service.

**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?

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.

Good



### Are services effective?

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. Appropriate training had been planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

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.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients, acted on suggestions and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients told us it was easier, following changes which had been made, to get an appointment. They could get to see a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good

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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

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 PPG was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. The practice were pro-actively joint working to support frail elderly patients and patients with multiple morbidities and aimed to keep them out of hospital. They did this by better assessment and speedy introduction of support services such as the re-enablement team. They worked closely with carers and care homes to establish a co-ordinated approach. We observed this on the day when the practice responded and supported an elderly carer who was not a patient of the practice, but whose husband was.

Good



### People with long term conditions

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. The practice held regular multidisciplinary and palliative care meetings. They had computer screen pop-ups to alert staff to any patients with infectious diseases and policies with instruction for staff on how to control the spread of any infection.

Good



### Families, children and young people

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. The practice were pro-active in safeguarding of children. All children under the age of five years were offered a full health check to identify any underlying potential illness or safeguarding issue. The practice nurse provided an example where early intervention had provided a positive impact for the patient.

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.

Good



# 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 reflected the needs for this age group. When the practice was closed patients had access to the Heywood Health Hub (HHH) which was an initiative set up by the lead GP at Heady Hill.

## **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 registers of patients living in vulnerable circumstances and those with a learning disability. It undertook checks on patients with learning disabilities and screen messages were available to alert staff of any patients at risk of self harm. The practice had several policies in relation to vulnerable patients which covered areas from mental capacity to guide dogs. When required, vulnerable patients and patients with a military background were highlighted as priority patients.

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). Health checks for people experiencing mental health issues were offered and 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 dementia checks and advanced care planning for patients with dementia. The practice had a screen message system in place for flagging alerts to all clinicians reviewing the patients and was one of two small practices in Heywood who cared for patients with addictions.

## 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. Staff had received training on how to care for people with mental health needs and dementia.



# Summary of findings

## What people who use the service say

We spoke with six patients who used the service on the day of our inspection and reviewed 21 completed CQC comment cards. The patients we spoke to were very complimentary about the service. They told us that they found the staff to be extremely person-centred and felt they were treated with respect. We spoke to vulnerable patients and patients with addictions and they reported that the GPs were very supportive and helped them considerably. The comments on the cards provided by CQC were also very complimentary about the staff and the service provided.

**The results from the 2015 GP national satisfaction survey showed :**

### What this practice does best

94% 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%**

83% of respondents are satisfied with the surgery's opening hours - Local (CCG) average: **72%**

85% of respondents would recommend this surgery to someone new to the area - Local (CCG) average: **74%**

### What this practice could improve

86% of respondents say the last nurse they saw or spoke to was good at listening to them - Local (CCG) average: **90%**

94% of respondents had confidence and trust in the last nurse they saw or spoke to - Local (CCG) average: **97%**

88% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern - Local (CCG) average: **91%**

## Outstanding practice

The practice were pro-active in their safeguarding of children. All children under the age of five years were offered a full health check to identify any underlying potential illness or safeguarding issue. The practice nurse provided an example where early intervention had provided a positive impact for the patient.

The practice had signed up to the electronic prescribing service and were rated the highest achieving practice in the Clinical Commissioning Group (CCG) with 90% of patients now receiving their prescriptions electronically. Patients we spoke with and evidence reviewed showed positive outcomes for patients in relation to this service.

# Heady Hill Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP adviser, a practice manager adviser and an expert by experience. An expert by experience is someone who has used health and social care services.

## Background to Heady Hill Surgery

The practice delivers primary care under a General Medical Services Contract between themselves and NHS England. As part of Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) they are responsible for a diverse population of 3329 patients within the surrounding areas of Hewood. The practice is fully computerised and registered under the Data Protection Act 1984.

The practice opens at 9.00am Monday to Friday and closes at 12.30pm until 1.30pm for lunch when the doors are locked. On Monday, Thursday and Friday the practice re-opens after lunch until 6pm, stays open until 8.00pm on a Tuesday and does not re-open on a Wednesday. On Wednesday afternoons the on-call doctor is available. Patient telephone consultations are available between 11.40am and 12.00pm every day. On the second Thursday afternoon of each month the practice closes in the afternoon for staff training.

The practice do not currently have early morning opening but this is due to change at the beginning of April when the practice will open from 8am until 6.30pm every weekday and increase appointments to 75 per 1000 patients per week.

When the practice is closed patients have access to the Heywood Health Hub (HHH). HHH is an initiative set up following a successful bid by the lead GP at Heady Hill. It is a central hub of medical staff including nurses and GPs (employed by Bardoc) and is open to all patients registered with a Heywood GP. Routine GP and nurse services operate from Heady Hill surgery between 4pm and 9pm Monday to Friday and from 9.30am until 8.30pm on Saturdays and Sundays. Patients also have access to the NHS Walk In Centre between 7am and 10pm every day.

Facilities are available for disabled patients with disabled toilets and car parking at the rear of the building. Wheelchair access to the building is through the main entrance.

Services include family planning, antenatal, diabetic, asthma, cardiac, chronic obstructive pulmonary disease (COPD) and hypertension clinics. There are also clinics for over 75 reviews, well person clinics, smoking cessation, flu and holiday vaccinations and minor surgeries.

The CQC intelligent monitoring placed the practice in band 4. 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.

There were no previous performance issues or concerns about this practice prior to our inspection.

# Detailed findings

## 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.

## 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 February 2015. During our visit we spoke GPs, Nurses, personal assistants and reception and administration staff. We also spoke with patients who used the service. We observed the waiting and reception areas and carried out a tour of the premises. We observed how were treated by reception staff and spoke to two members of the Patient Participation Group (PPG).

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety such as reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed an incident about medication when a patient is discharged from hospital. We spoke with staff who were aware of the incident and what was done to resolve it, and they were able to give us examples of other incidents.

We reviewed safety records, incident reports and minutes of meetings over the previous 12 months where we saw that incidents had been discussed. The practice held 'learning time' meetings once a month. We saw that the practice managed incidents, complaints and significant events consistently over time.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed at monthly 'learning meetings' or at other times when required. Complaints were also openly discussed and reviewed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms to complete information and these all were kept in a folder together. We reviewed the system used to track incidents and saw evidence that the practice had learned from these. Findings were shared with relevant staff. Examples we saw included action to be taken to avoid re-occurrence of the incident in the future. We saw that practice had changed following an incident and a system was introduced to ensure patients discharged from hospital had the correct discharge medicines recorded on their electronic record. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts received were disseminated to appropriate staff by the personal assistants (PAs). The lead GP received alerts through the Clinical Commissioning Group (CCG) and passed them on to other practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Alerts were also discussed at practice meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Locum staff were included in the dissemination of any information.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. We were shown where relevant information appeared on the patient summary. Examples included details of patients with learning disabilities, children in foster care, elderly patients and any other information that any GP reviewing the patient should be aware of.

All children under the age of five years were offered a health check which enabled the examining GP to identify any potential underlying illnesses or any potential safeguarding issues. Health visitors would be informed if children under five left the practice, regardless of the reason.

## Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as an advocate for a patient and health care professional during a medical examination or procedure). All clinical and non clinical staff had received chaperone training which had been delivered by the lead GP in August 2014. Administration staff would act as a chaperone if nursing staff were not available. We spoke to staff who explained how they would carry out this duty and were satisfied that all aspects, including where to stand and how to record the event had been covered. We saw an example where details of an attendance had been recorded by the chaperone in a patient record. All staff who undertook chaperone duties had received an enhanced Disclosure and Barring Service (DBS) check.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. GPs were responsible for the medicines in their own bags. We reviewed the medicines in the doctors' bags and found they were all in date and contained those required to deal with emergency situations such as allergic reaction, acute infection and/or heart failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. GPs administered joint injections. We saw up-to-date copies of both sets of directions and evidence that the nurse's training was up to date.

The practice had signed up to the electronic prescribing service and were rated highest achieving practice in the CCG for usage. 90% of all patients were now receiving their prescriptions electronically. A screen message appeared for patients who had 'opted out' and there were stringent security checks in place before prescriptions were issued. There were arrangements to ensure that patients collecting

medicines from their nominated locations were given all the relevant information they required and there was an alert system to ensure that blood test results were reviewed before prescriptions were authorised.

All prescriptions were reviewed and signed by a GP before they were issued to the patient. Patients receiving repeat antidepressant medicines were called for three and six month reviews. All other patients on repeat medicines received an annual medicine review by the lead GP. Blank prescription forms for things such as home visits and locums were handled in accordance with national guidance and these were tracked through the practice and kept securely at all times. There was a specific member of staff responsible for the management of prescription ordering and issuing. We observed that they were very knowledgeable and helpful in this role and saw that they received regular support and supervision from the lead GP. We saw that the practice were continually reviewing the quality of the prescription service they provided.

### Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The senior partner was the lead for infection control and disseminated information updates to staff when they were received. We saw that four members of staff had attended infection control training delivered by Rochdale Council in April 2014. Other staff had received in-house training on hand washing technique only which had been delivered by one of the PAs. All staff had received induction training about infection control specific to their role. We saw evidence that an audit had been undertaken by Rochdale Council in 2014 and that any improvements identified for action were completed on time. A public health inspection had also been undertaken and the practice had received 84% compliance. Minutes of practice meetings showed that the findings of the audits were discussed. Audit checks were carried out by the PAs on a regular basis and we saw four reports from the year 2014 where any issues identified were rectified.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal

## Are services safe?

protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy such as when taking blood samples or providing joint injections. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A risk assessment was undertaken in 2012 and again in February 2014. Legionella sampling was done in February which was negative. The practice also carried out monthly water temperature checks.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. In addition we saw emergency equipment such as fire extinguishers, oxygen and a defibrillator. The practice told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs, certificates and other records that confirmed this. There was a fridge in the nurse's room for the storage of medicines and vaccinations and a spare fridge was available in another room in case of break down. Both fridges were calibrated and hard wired.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The practice used the same suppliers consistently so they could contact them when checks were due or if equipment broke down.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We spoke to a new member of staff who told us she would be expected to cover if another person was on leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice nurse was part time and there was a phlebotomist at the practice. Staff agreed that more nursing time would be of benefit. The practice were addressing this.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, they had shared findings from an infection control audit with the team. We also saw examples of clinical and staffing risks which were identified, shared with relevant staff and monitored to reduce the impact on the practice and the patients.

All patients requesting urgent on the day appointments were seen at some point during the day of their request. These appointments were designed to address specific urgent issues that could not wait for a routine appointment.

The practice had clear guidelines on repeat prescriptions for patients with long standing conditions and checks were made to ensure the patients were managed within these guidelines. Patients on complex or restrictive medication were given limited amounts of their medication to ensure



## Are services safe?

safety of the person and the medicine. An example of this was antidepressant medication which was only given in sufficient amounts before the patient was due to be seen for review.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). There were no signs to show the location of the emergency equipment but all staff spoken with knew where it was and we saw records that these were checked regularly. We saw panic buttons located in treatment rooms and message alerts which could be used to alert staff for help when required.

There was an up to date business continuity plan which set out the major perceived threats to the practice's normal ways of working. It clearly detailed the action plans, people to contact and action to be taken to deal with any issue

that might occur. Staff were aware of the plan and what to do in the event of emergency. A copy of the plan was kept at the houses of some of the staff members in the event of fire or destruction of the building.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The GPs did not routinely carry stocks of medicines for the treatment of emergencies on home visits. However patient symptoms were reviewed before the visit and specific medicines would be taken if felt required, such as if a child had a severe temperature or unidentified rash. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that fire drills were undertaken. Risks associated with service and staffing changes (both planned and unplanned) were monitored. We saw that staff were able to cover each other when required and specifically saw that GPs had covered each other during long term unplanned absence.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Care plans were used to identify need specifically in older people, and people with mental health conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

National data showed that the practice was in line with targets for cancer screening and referral rates to secondary and other community care services for all conditions. The practice were part of peer review within the Clinical Commissioning Group (CCG) which looked at the quality of their referrals and audited whether or not they were appropriate.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the PAs and other staff to support the practice to carry out clinical audits.

The practice showed us a number of audits that had been undertaken over the last two years. Four of these were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. It had been identified that Heady Hill surgery were the third highest antibiotic prescriber within the borough. Monitoring was undertaken to find the reasons for this and results and an action plan were put in place. Actions included rechecking antibiotic prescribing on a weekly basis. The information was discussed each week at the practice meeting and information on national guidelines was displayed in all consulting rooms and within a folder for locum GPs. A similar audit with similar actions was undertaken for benzodiazepines (an addictive medicine used in the treatment of anxiety disorders) to identify and reduce prescribing where appropriate.

Other regular auditing and outcome monitoring included flu audits, patients at risk of dementia, shingles immunisations, carers and child protection patients. The practice also worked closely with drug management teams within the CCG and a drug worker came in to the practice to work with the lead GP when required. We heard excellent examples by clinicians where positive outcomes had been achieved for patients around drug management.

We saw that clinical audits undertaken were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

There was a protocol for repeat prescribing which was in line with national guidance. There was a dedicated member of staff who regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The



# Are services effective?

## (for example, treatment is effective)

electronic prescribing system flagged up relevant medicines alerts when the GP was prescribing medicines. We were shown how the system could evidence that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and the lead GP had an additional diploma in ear, nose and throat (ENT). The GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. The lead GP for this practice was the first GP in Heywood Middleton and Rochdale to be revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff received annual appraisals where learning needs were identified and training was planned in accordance with those needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. A new member of staff employed as a receptionist asked if they could do a phlebotomy course and this was agreed and sanctioned. Three monthly and six monthly supervision and probation periods were in place for new members of staff. Locum GPs had access to peer support by the substantive GPs.

The practice nurse had a defined role and was able to demonstrate that they understood that role and were trained to fulfil their duties. They received regular clinical supervisions from the GPs and were supported with their continuing professional development. They undertook the administration of vaccines, cervical cytology, chlamydia testing, child health surveillance and child and travel immunisations. The practice nurse also helped manage patients with long-term conditions such as COPD (chronic obstructive pulmonary disorder), asthma, diabetes and heart conditions.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook regular audit of follow-ups (in line with the CCG and Local Area Team (LAT)) to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. In addition the practice held monthly long term condition meetings, learning time meetings and the lead GP attended monthly locality CCG meetings with one of the personal assistants (PAs).

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made approximately 80% of

# Are services effective?

## (for example, treatment is effective)

routine referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. Other referrals such as urgent or 'two week waits' were paper based.

For emergency patients, there was a policy of providing a printed copy of a summary record or a typed letter for the patient to take with them to accident and emergency (A&E).

The practice had systems to provide staff with the information they needed. Staff used EMIS which is an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Letters from the local hospitals came in electronic form to the practice into an electronic system. These letters were then forwarded to the GPs and all GPs covered each other during times of leave so that no letters were missed. All GPs were set up to see each other's patient test results so that results did not get missed.

### Consent to care and treatment

Medical and clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice including do not attempt resuscitation orders. There was a policy specific to mental capacity which outlined the requirements of The Act. It also gave guidance and assistance to staff who were not clinical about mental capacity or scenarios where capacity to make decisions was an issue for a patient.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient

did not have capacity to make a decision. We saw an example where a husband had given consent for his wife, who was his carer, to be involved about decisions in his care and treatment.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

### Health promotion and prevention

The practice met regularly with the CCG to discuss the implications and share information about the needs of the practice population. The information was used to help focus health promotion activity.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GPs would use their appointments with patients to talk about mental, physical health and wellbeing and would offer opportunistic checks such as smoking cessation, alcohol and drug advice and diet advice when necessary. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients with dementia were offered full in-house checks and if identified as needed included MRI scans and referral to the memory clinic.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. They kept a register of all patients with a learning disability who were offered an annual health check. The health care assistant was responsible for following up patients who did not attend screening and new patient health checks were offered by the practice nurse.

# Are services effective?

(for example, treatment is effective)

According to the most recent General Practice Outcome Standards (GPOS) Heady Hill were a higher achieving practice within the CCG. .

The practice had strong links to the Heywood and Middleton locality, the CCG and the local Health and Wellbeing Board which is a forum where key leaders across the health and social care system work together to improve health and reduce inequalities within its local population. Patients over 50 had been referred to a group called

“Circle” and this was done through the patient participation group (PPG). Circle provide social and practical support and arrange healthy events and social activities. There was a range of leaflets in the entrance way to reception including support organisations for drugs and alcohol, young carers, MIND, multiple sclerosis. There was also a carer’s noticeboard and a notice asking carers to make themselves known to reception.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

Most patients we spoke with felt the practice offered an excellent service and staff were efficient, helpful and caring. We received negative feedback from one patient who was concerned that they could no longer see the GP of their preferred choice when they wanted to do so, unless they booked this appointment several weeks in advance. Patients reported that staff treated them with dignity and respect. We spoke with ten patients in total on the day of the inspection.

There was no glass partition to help keep information private at reception and reception was quite open within a small waiting area. Privacy was slightly compromised but there was a notice saying that people could speak in private if they needed to. Consultations were carried out behind closed doors and conversations could not be overheard. We saw that privacy had been discussed and included in the the patient participation group (PPG) survey questionnaire. More than half the patients felt they could be overheard but didn't mind and a very small percentage (around 10%) did mind. The practice had not specifically detailed privacy as an item on their plan for change, but they had identified redesign of the building and would be looking at privacy within the redesign.

We saw external ramps to assist patients using wheelchairs and pushchairs and entrance doors were power assisted. Consultation rooms were on the ground floor and the waiting room area was warm with enough space. There was no lift to the upstairs but there were no clinic rooms upstairs and the person who dealt with prescriptions came downstairs if required. Breast feeding and baby changing facilities were available.

We observed staff being helpful and non-judgemental towards patients and when interviewed staff said they treated everyone as equal. Equality and diversity training was being delivered to all staff on the day of the inspection by Rochdale Council.

### Care planning and involvement in decisions about care and treatment

Information from the latest national GP survey confirmed that 94% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the local (CCG) average of 82%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We received many examples from patients and staff about positive outcomes for patients of the practice. We spoke with patients whose whole families (grandparents to grandchildren) received care from the surgery. We spoke to patients who were carers, parents with children with learning disabilities and patients with who attended for drug misuse management. All were very complimentary about the practice and the GPs and the support they had received. Patients we spoke to and comments we received on CQC comments cards detailed stories about how the GPs went 'above and beyond' to support them.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Information was not currently available in different languages but plans to create new leaflets at the beginning of April would address this.

### Patient/carers support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations for issues such as epilepsy, memory, migraine, bowel cancer, drug and alcohol issues and mental health conditions. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. There was also a range of information on a carers' noticeboard.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and

## Are services caring?

location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. One patient who was very well known to the practice told us how both GP partners had visited together to support the family when their father was dying.

We saw evidence of emotional support by all members of staff. Particularly on the day of the inspection we witnessed support for a carer whose husband was a member of the practice, but she was registered at a different practice. We saw how an information sharing protocol was set up with the wife's own GP and saw how the two practices worked in partnership to support these patients together as much as possible.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

We saw evidence that the practice was regularly engaged with the Clinical Commissioning Group (CCG) and other organisations such as the Health and Wellbeing Board to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where discussions had taken place and actions agreed to implement service improvements and manage delivery challenges to its population. We saw that the practice tried to respond to the needs, not only of its own patients, but the patients of the entire community.

In particular the lead GP for the practice had successfully bid for and secured funding to set up the Heywood Health Hub which is still in the pilot stage. The bid came from a desire by the GP to work in federation to create better access to GPs and A&E for patients in the locality. In its first year the Heywood Health Hub had provided an extended hours 7 day a week GP and nurse service in Heywood and had the input of a multi skilled worker at A&E and another in the community. GPs (provided by the out of hours service) provide the extended hours support and the records of patients seen at the Hub are available to the GPs providing the service. Each practice has a specific number of priority appointments but if the appointments are not used by that practice they can be utilised by any patient across the six practices involved in the scheme.

The multi-skilled worker in A&E identified patients who had attended for social problems which were inappropriate for A&E and discharged them home with social support. The community multi-skilled worker visited older people who lived independently and were on four or more repeat medications. They assessed their eyes, ears, falls, feet, social support and activities of daily living. They then made referrals when required to services such as ophthalmology,

audiology, the falls risk assessment team, and occupational or physiotherapy. They also wrote detailed care plans for these patients. The Hub reduced inappropriate referrals and provided greater access to a GP for patients in the whole community for longer hours.

### Tackling inequity and promoting equality

The practice was small and the staff knew most of the patients very well. There was little cultural or racial diversity but staff knew how to access translation services if they were required. Equality and diversity training was provided and on the day of inspection this was being delivered by the local council.

The premises were suitable to meet the needs of patient with disabilities. There was plenty of room for wheelchairs, ramps and automatic doors were in place, there was a hearing loop if required, and a guide dog policy.

The practice had a screen message system in place for flagging vulnerable patients. This practice was one of two small practices in Heywood who cared for patients with addictions.

### Access to the service

The practice opened at 9.00am Monday to Friday and closed at 12.30pm until 1.30pm for lunch when the doors were locked. On Monday, Thursday and Friday the practice re-opened after lunch until 6pm, stayed open until 8.00pm on a Tuesday and did not re-open on a Wednesday. On Wednesday afternoons the on-call doctor was available.

Patient telephone consultations were available between 11.40am and 12.00 noon every day. On the second Thursday afternoon of each month the practice closed in the afternoon for staff training. When the practice was closed patients accessed the on call service. They also have access to the NHS Walk In Centre between 7am and 10pm every day. Patients also had access to routine GP and nurse services from Heady Hill surgery through HHH between 4pm and 9pm Monday to Friday and from 9.30am until 8.30pm on Saturdays and Sundays.

The practice did not currently have early morning opening but this was due to change at the beginning of April when the practice would open from 8am until 6.30pm every weekday and increase appointments to 75 per 1000 patients per week.

# Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

## **Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its 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 at reception and on the practice website to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a formal complaint about the practice.

We looked at three complaints received in the last 12 months and found that they were satisfactorily handled and dealt with in a timely way. Actions for change were made where appropriate and the practice discussed the complaints openly and took learning points from them.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been 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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly outlined in the practice statement of purpose and within the practice leaflet. The practice wanted to provide the very best in general medical service and took pride in being a whole person centred diagnostic and management service. This was evident on speaking to the GPs at the practice and the staff. We spoke to seven members of staff in total and they all understood the practice vision and knew what their responsibilities were in relation to them.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All eight policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. The senior partner was the lead for infection control and for safeguarding. Other staff had dedicated duties such as prescriptions, secretarial and practice management. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its 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 monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken in particular with regard to the prescribing of antibiotics and benzodiazepines (hypnotic drugs used in the treatment of anxiety disorders).

These medicines were discussed every week in order to reduce any inappropriate prescribing, all staff (including locum and administration staff) were involved and results showed that prescribing had reduced.

The practice held regular governance meetings where performance, quality and risks were discussed.

### Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every month and were used to provide training and open discussions about the service.

Each partner in the practice had a personal assistant and practice management duties such as human resource policies and procedures were shared by them. We reviewed a number of policies, including recruitment, induction and the staff handbook which included sections on sickness, equality and harassment and bullying at work. There was also a practice whistleblowing policy and staff we spoke with knew where to find these policies if required.

### Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient satisfaction questionnaires, the friends and family test, informal comments and suggestions made via their suggestions box. We looked at the most recent patient satisfaction questionnaire. Patients had reported difficulty getting through on the telephone to make an appointment and stated that when they did get through there were no appointments left. The practice dealt with this by adding an extra appointment to each surgery and by making sure that there were always two surgeries running. In order to achieve this and to ensure continuity of care, the practice employed regular locum GPs. The practice were achieving the recommended targets of 70 face to face GP appointments per 1000 patients and planned to increase this from 1st April to 75.

The practice gathered feedback from staff through away days, appraisals and staff meetings. Staff told us they would not hesitate to give feedback and felt they could



# Are services well-led?

Good 

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

discuss any concerns or issues with colleagues or managers. A recently employed member of staff had asked for extra training to become a phlebotomist and this had been sanctioned.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that

regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice but did not currently have any trainee GPs.

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