The Dale Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 7

What people who use the service say 11

Areas for improvement 11

Detailed findings from this inspection

Our inspection team 12

Background to The Dale Medical Practice 12

Why we carried out this inspection 12

How we carried out this inspection 12

Detailed findings 14

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Dale Medical Practice on 11 April 2017. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed low satisfaction rates when patients were asked if they felt that they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. The practice were adjusting its services and monitoring patient satisfaction on a monthly basis and had seen an improvement.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- 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 provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- All staff employed by the practice had received a check with the Disclosure and Barring Service.

The area where the provider should make improvement is:

- The practice should further improve , embed and monitor patient satasfaction in the services provided.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice held data of all adults living with protected children.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- The practice worked with the local mosques to encourage patients to take up NHS health checks offered to them.
- The practice had achieved level three, the highest level, in the Primary Care Improvement Standards which is CCG led.
- Urgent referrals were processed the same day and routine referrals were usually processed within two days.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice lower than others for several aspects of care. More recent data provided by the practice and the Family and Friends test show that patient satisfaction had improved since the last national survey had been carried out.
- Results from the national GP patient survey showed low satisfaction rates when patients were asked if they felt that they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. The practice were adjusting their services and monitoring patient satisfaction on a monthly basis and had seen an improvement.Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice made comfort calls to its vulnerable patients.
- Same day appointments were available for children under the age of 12 years.
- A dedicated emergency telephone line was made available to district nurses, the local nursing homes and A&E at the local hospital.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. Some staff and all of the GPs were able to speak Urdu in response to the high number of patients that did not have English as a first language.
- Leaflets and posters were available in English and Urdu. The practice were in the process of developing information in other languages.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- The practice were successful in a bid for funds to deliver a Patient Education Programme including language specific education workshops in conditions such as diabetes.
- Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and evidence from four examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had a Life channel information screen in the waiting area which played information about health conditions and how to get support.
- The practice were about to be launched as a Homelessness Friendly practice. This meant that homeless people would be able to register and use the practice address for correspondence. Walk in appointments would be available for these patients.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In seven examples we reviewed we saw evidence that the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.
- The practice worked with a group of local practices to share expertise, enhance staff support and deliver best practice.

Summary of findings

- The doctors contributed to health promotion on local and national radio, write a health promotion column for Rochdale Online and attend health sessions at the local community centre.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- Dementia screening and seasonal immunisations were offered to all its older patients.
- The practice referred to the continence team, falls team and social services when required.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less was 84% compared to the CCG of 79% and the national average of 80%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

Summary of findings

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health. For example patients with COPD were offered personalised "Flare up" plans.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice were involved in the CCG "Test Beds" initiative which helped patients self manage their long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes, which included links with midwives and health visitors, for acutely ill children and young people and for acute pregnancy complications.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example the practice worked with GP Care services to provide seven day access to a GP.

Summary of findings

- The practice offered electronic prescribing which meant that a patient could nominate a pharmacy where the GP sends prescriptions to, making the whole process more efficient and convenient for the patient.
- 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.

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.
- At the end of April 2017 the Mayor of Rochdale was to attend the practice to launch it as a "Homeless Friendly Practice". This meant that homeless patients would be able to register as a patient, use the practice address for correspondence and walk in to see a GP when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- The practice offered comfort calls to its patients who were vulnerable.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.

Summary of findings

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia whilst taking into account the patients cultural beliefs and ethnic understanding.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% which was above the CCG average of 87% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing lower than local and national averages. 354 survey forms were distributed and 51 were returned. This was a response rate of 14% and represented 2% of the practice's patient list.

- 49% of patients described the overall experience of this GP practice as good compared with the CCG average of 82% and the national average of 85%.
- 39% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 27% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the national average of 78%.

This provider had been formed in 2014 and had improved access to GPs and a practice nurse. They were continually monitoring patient satisfaction through their own surveys and the NHS Family and Friends test. They provided evidence of an improvement in patient satisfaction, for example the latest results from the Family and Friends questionnaire showed that 74% of patients would recommend the practice to someone new to the area. The practice provided results from its own latest survey which showed that 91% of patients stated that the quality of services was good, very good or excellent.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which were all positive about the standard of care received.

The practice provided a video recording of two patients who had recorded comments about the practice and both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service SHOULD take to improve

- The practice should further improve , embed and monitor patient satasfaction in the services provided.

The Dale Medical Practice

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 specialist adviser and a practice manager specialist adviser.

Background to The Dale Medical Practice

The Dale Medical Practice provides primary medical services in Rochdale from Monday to Friday. The practice is open:-

Monday, Thursday and Friday 8:30am – 6pm

Tuesday 8:30am - 7:15pm

Wednesday 8:30am – 1pm

Appointments with a GP are available:-

Monday, Thursday and Friday 9:30 – 12pm and 3pm – 5:30pm

Tuesday 9:30am – 12pm and 3pm – 6pm.

Wednesday 9:30am – 12pm.

Appointments with a practice nurse are available until 7:15pm every Tuesday.

The Dale Medical Practice is situated within the geographical area of Heywood, Middleton and Rochdale Commissioning Group (CCG).

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The Dale Medical Practice is responsible for providing care to 2450 patients.

The practice consists of one female GP partner, one male GP managing partner, one male salaried GP and one long term locum GP. The practice also has one practice nurse and one health care assistant and is supported by a practice manager and a reception and administration team. The practice is a teaching practice with regular fourth and fifth year medical students.

When the practice is closed patients are directed to the out of hours service provided by BARDOC (Bury and Rochdale Doctors On Call).

The practice worked in partnership with GP Care Services to offer seven day access to a GP.

Why we carried out this inspection

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. The 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

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 11 April 2017. During our visit we:

Detailed findings

- Spoke with a range of staff including GPs, the practice partners, the practice manager, the practice nurse and members of the administration team. We saw a video recording, provided by the practice, of two patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of seven documented significant events we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared within the practice and with other local cluster practices and action was taken to improve safety in the practice. For example emergency call instructions were displayed in all clinical rooms following a clinical emergency in one of the treatment rooms.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child protection or child safeguarding level three. The practice were aiming to train all staff to a level three and had ensured that access was made available to staff to achieve this.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice manager was the non clinical lead working with the practice nurse in this along with a member of the administration team acting as deputy.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in

line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice had displayed emergency call instructions in all rooms following a clinical emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 96%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was higher than the CCG and national averages. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/1 or less was 84% compared to the GGC average of 79% and the national average of 80%.
- Performance for mental health related indicators was higher than the CCG and national averages. 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their record in the preceding 12 months compared to the CCG average of 87% and the national average of 89%.

There was evidence of quality improvement including clinical audit:

- There had been several full cycle and single clinical and non clinical audits commenced in the last two years, we were provided with examples of completed audits where improvements made were implemented and monitored including checking that patients on more than four medicines had received the relevant investigations.
- Findings were used by the practice to improve services. For example, recent action taken as a result included patient education workshops, in different languages for patients with long term conditions such as diabetes and asthma.
- The practice also carried out non clinical audits which looked at for example, patient appointments and referrals which were discussed at practice meetings and cluster meetings.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, discussion at practice meetings and the local practice nurse forum.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. All new staff had reviews after three months with a full appraisal planned.

Good

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, face to face training and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition.
- A healthy lifestyle clinic was held at the practice for those patients that required advice on their diet, smoking and alcohol cessation and weight management. Patients who were unable to attend at the surgery were signposted to other clinics within the local cluster.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 80% and the national average of 81%. The practice were working with the local mosques, the local radio station and Rochdale Online and held patient education sessions in specific languages in order to improve the uptake rate of screening for breast and bowel cancer. The practice also followed up patients who did not attend for screening by writing to them and issuing information leaflets.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to national averages. For example, rates for the vaccines given to under two year olds ranged from 83% to 97% and five year olds from 88% to 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast

Good

Are services effective?

(for example, treatment is effective)

cancer by working with the local mosques, the local radio station and Rochdale Online and held patient education sessions in specific languages in order to improve the uptake rate of screening.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the nine patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We saw a video recording, provided by the practice, of two patients who commented about the practice who said that they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed low results when patients were asked if they felt they were treated with compassion, dignity and respect. The practice was lower than average for its satisfaction scores on consultations with GPs and nurses. For example:

- 55% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 52% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 75% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%
- 52% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 77% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 74% of patients said the nurse gave them enough time compared with the CCG average of 92% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 71% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 53% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

During the last two years the practice had undergone a number of changes when the current provider took over running the practice. They went through a period of locum cover with only one regular GP and the previous practice nurse retired. The practice had recruited a new GP and nurse and increased the nursing hours. The practice regularly monitored patient satisfaction during the changes made and provided the results of a recent survey taken by the practice where

91% of patients stated that the quality of services was good, very good or excellent.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received was positive. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages. For example:

- 50% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.

Good

Are services caring?

- 41% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 75% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 52% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice had recently employed a full time GP who spoke Urdu and we were told that they were now receiving good feedback due to consistency and continuity of care and patients were able to attend consultations and speak in their own language. Most recent Family and Friends test results and internal survey results showed an improvement.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation 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. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in different languages and in an easy read format.
- The NHS e-Referral service was used with patients as appropriate. (this is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 33 patients as carers (1.3% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday evenings until 7.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children under the age of 12 and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Bi lingual members of staff and a GP were employed to hold conversations with patients who did not speak English as a first language.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- Leaflets and posters were available in different languages.

Access to the service

The practice was open between 8.30am and 6pm Monday, Tuesday, Thursday and Friday, and between 8:30am and 1pm on Wednesday. Appointments were from 9.30am to 12pm every day and 3pm to 5.30pm daily Monday, Thursday and Friday and until 6pm Tuesday. Extended hours appointments with the practice nurse were offered until 7.15pm every Tuesday. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 51% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 23% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 58% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 79% and the national average of 85%.
- 60% of patients said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 39% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 30% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 56% and the national average of 58%.

During the last two years the practice had undergone a number of changes when the current provider took over running the practice. They went through a period of locum cover with only one regular GP. The practice had recruited a new GP and increased the nursing hours and were introducing a new telephone system shortly, however It was too soon to measure how this had impacted on the practice.

The practice worked in partnership with GP Care Services to offer patients seven days access to a GP, however the practice told us that their patients were reluctant to utilise this service as they preferred to see their own GP.

The practice had a system to assess:

- whether a home visit was clinically necessary; and

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- the urgency of the need for medical attention.

Details of requests were passed to one of the GPs who triaged the request and in cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system 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 to help patients understand the complaints system

We looked at four complaints received in the last 12 months and found that these were dealt with in a timely way with openness and transparency when dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care, for example all staff were trained in communication and telephone skills and conflict resolution to avoid mis-communication with patients.

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.

- The practice had a mission statement which was displayed in the office area and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as HR, clinical governance, safeguarding, social media and student training.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- Weekly team briefings were held where staff workload was reviewed.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.
- The practice monitored the results of the Family and Friends test on a monthly basis and carried out its own surveys and were able to evidence an improvement in patient satisfaction.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

Are services well-led?

Good

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

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice were to introduce a new telephone system shortly.
- the NHS Friends and Family test, complaints and compliments received
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The practice were wanting to offer Minor Surgery and had a trained GP waiting for approval.
- The practice was using Zoom which is a video conferencing facility which would mean that GPs and staff would be able to attend meetings by video, saving time out of the surgery.
- One of the doctors planned to extend the medical student teaching within the practice.
- The practice were planning to offer triage by the practice nurse who had been trained by BARDOC prior to her employment.
- The practice wished to offer Saturday appointments but they told us that they were restricted because of the building opening times.
- The practice aimed to continue measuring patient satisfaction and adjust its services accordingly.
- At the end of April 2017 the Mayor of Rochdale was to attend the practice to launch it as a “Homeless Friendly Practice”. This meant that homeless patients would be able to register as a patient, use the practice address for correspondence and walk in to see a GP when required.