Ashworth Street Surgery

Quality Report

Ashworth Street Surgery
85 Spotland Road
Rochdale
OL12 6RT
Tel: 01706 346767
Website:
www.ashworthstreetsurgeryrochdale.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 12 February 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Ashworth Street Surgery on 1 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice, with other practices in the Clinical Commissioning Group and the wider NHS, had receptionists who were trained as care navigators who signposted patients to the right person at the right time across a variety of health services.

We saw one area of outstanding practice:

- The patients' group organised a Saturday morning Health Check event every other year where patients could attend and take advantage of a free NHS health check. Invitations were sent to 145 patients who had not attended the practice for over five years and those that had not responded previously for an NHS health check.Other service providers such as Mcmillan, Carers Resource, Alzheimers Society, MIND and CIRCLE (a befriending support group for isolated patients) were

Summary of findings

invited and offered information, support and guidance. 79 patients had attended the last event. As a result many patients had been identified who required further primary or secondary care treatment,for example, significantly high blood pressure, high cholesterol, pre diabetes and asthma. There was evidence that the intervention which occurred as a result of the health check impacted on health outcomes.

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

Ashworth Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector**.** The team included a GP specialist adviser, a practice manager adviser and an expert by experience.

Background to Ashworth Street Surgery

Ashworth Street Surgery, 85 Spotland Road, Rochdale, OL12 6RT is located in Rochdale, Greater Manchester and provides general medical services to patients within the Heywood, Middleton and Rochdale Clinical Commissioning Group area.

The practice have a branch surgery at Norden Old Library, Edenfield Road, Norden, OL11 5XE which was not visited on this inspection.

The practice website is www.ashworthstreetsurgeryrochdale.co.uk.

Since the last inspection the practice list of registered patients has increased from 11,121 to approximately 12,500.

Information taken from Public Health England placed the area in which the practice is located as second on the deprivation scale of one to ten. (The lower the number the higher the deprivation). In general, people living in more deprived areas tend to have greater need for health services.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training to level three. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- All prescriptions that were collected from the surgery either by the patient, a family member or a pharmacy were signed for and the clinical system marked up and coded appropriately. Those prescriptions that had not been collected were coded on the clinical system which enabled the practice to carry out a full audit of all prescriptions and to identify any trends and problems.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. All non clinical staff were trained in all areas of the reception and administration and provided cross cover when required.
- There was an effective induction system for temporary staff tailored to their role such as student doctors. The practice did not use locum GPs and used a buddy system for cover when clinical staff were on annual leave or sickness.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The practice had recently held a training event on sepsis and other severe infections.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Weekly clinical meetings were held where "hot topics" were discussed.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal

requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following a significant event where there were patients with a similar name, further checks were put in place before prescriptions were issued and referrals were made.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Data showed that the practice were a lower prescriber of hypnotic drugs than the CCG and national averages. (Hypnotic drugs are a group of drugs that reduce anxiety, aid sleep or have a calming effect)
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. The community nurse practitioner, employed by the practice carried out these assessments in the patients home when required.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had carried out 782 health checks on this group of patients.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice employed a community nurse practitioner who routinely carried out well being visits to its elderly patients who were unable to leave their homes.
- Elderly patients who were ill, vulnerable or isolated were given the telephone number of their usual GP so that they could contact them when needed.
- The GPs were accessible out of hours and carried out comfort visits to their seriously ill patients.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Patients suffering from asthma and chronic obstructive pulmonary disease (COPD) had care plans in place and were given stand by medication for exacerbations where appropriate.
- The practice offered in house electrocardiograms (ECGs), 24 hour blood pressure monitoring and C-reactive protein blood tests. Echocardiograms (ECHOs) an anticoagulation clinic were carried out by other providers at the surgery.
- The practice nurse was attending a Mcmillan course called Living with Cancer. This meant that all patients in this group would have a care plan and would be offered more than medication, such as being signposted to weight, smoking and activity advice and signposting them to family support, counselling services and to what benefits may be available.
- The practice held a register of patients with a fatty liver. These patients were screened and reviewed annually.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Urgent, same day appointments were available for children when required.
- The practice offered a comprehensive contraceptive service which included implants, depo injections, intrauterine devices and emergency contraception.
- All staff had received paediatric basic life support training.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 81%, which was in line with the 80% coverage target for the national screening programme.

Good

Are services effective?

(for example, treatment is effective)

- The practice had systems to inform and invite all eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice offered extended hours appointments early mornings, evenings and some Saturdays for patients that were unable to attend the surgery during normal working hours.
- Patients were able to book appointments and order prescriptions online.
- Patients were able to use the electronic prescription service where they could nominate a pharmacy where the GP sends repeat prescriptions to, making the whole process more efficient and convenient for them. 60% of patients were now using this service.
- Receptionists were trained to signpost patients to the right person at the right time across a variety of health services.

People whose circumstances make them vulnerable:

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Longer appointments or home visits were offered to patients according to their needs.
- Fast track appointments were offered to distressed patients to minimise time spent in the waiting area.
- The practice provided care to a local residential facility for adults with complex psychiatric needs.
- The practice employed a community nurse practitioner who carried out home visits to carry out health reviews, blood tests and health screening to its vulnerable patients who were unable to leave their homes.
- The practice had a number of leaflets and the practice survey translated into other languages for patients whose first language wasn't English.
- The practice had signed up to the Rochdale Health Alliance Homelessness project and had donated flu vaccine for homeless people not registered with a GP. Members of the practice had volunteered to become part of the Homeless Outreach Service

People experiencing poor mental health (including people with dementia):

- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months compared to the national average of 84%.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months compared to the national average of 89%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 95%; CCG 91%; national 90%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 96%; CCG 96%; national 95%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example one of the GPs had redesigned the diabetic service provided by the practice. Where appropriate, clinicians took part in local and national improvement initiatives such as the NHS Care Navigation programme where receptionists were trained to signpost patients to the right person at the right time across a variety of health services.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. The overall exception reporting rate was 5% compared with a national average of 6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear process for supporting and managing staff when their performance was poor or variable although the practice told us that this had never needed to be used.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- 63% of new cancer cases were referred using the urgent two week wait referral pathway which was above the CCG average of 56% and national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- All but three of the 77 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.
- The practice had signed up to the Rochdale Health Alliance Homelessness project and had donated flu vaccine for homeless people not registered with a GP. Members of the practice had volunteered to become part of the Homeless Outreach Service.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 282 surveys were sent out and 124 were returned. This was a response rate of 44% and represented about 1% of the practice population. The practice was the same as or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 95% of patients who responded said the GP gave them enough time; CCG average - 88%; national average - 86%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG average - 95%; national average - 95%.
- 98% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG average - 86%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; CCG average - 91%; national average - 91%.
- 93% of patients who responded said the nurse gave them enough time; CCG average - 92%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG average - 97%; national average - 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG average - 90%; national average - 91%.
- 96% of patients who responded said they found the receptionists at the practice helpful; CCG average - 87%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 225 patients as carers (2% of the practice list).

- A member of staff acted as a carers' advocate 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 and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with or above local and national averages:

- 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.
- 94% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG average - 82%; national average - 82%.
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG average - 90%; national average - 90%.
- 85% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG average - 85%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services with the exception of people with long term conditions which we rated as outstanding.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments .
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. The practice had employed a community nurse practitioner to provide servies in patients own homes where required.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had a good skill mix of staff which included a community nurse practitioner and advanced nurse practitioner who were able to provide holistic, social and medical care for patients in need, in their own homes.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and community nurse practitioner also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Elderly patients who were ill, vulnerable or isolated were given the telephone number of their usual GP so that they could contact them when needed.
- The GPs were accessible out of hours and carried out comfort visits to their seriously ill patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients suffering from asthma and chronic obstructive pulmonary disease (COPD) had care plans in place and were given stand by medication for exacerbations where appropriate.
- The practice offered in house electrocardiograms (ECGs), 24 hour blood pressure monitoring and C-reactive protein blood tests. Echocardiograms (ECHOs) an anticoagulation clinic were carried out by other providers at the surgery.
- The practice nurse worked closely with patients suffering from chronic obstructive pulmonary disease (COPD) and enrolled them onto the Closer Care programme which is a pilot programme at present. Patients were identified by the practice who were then shown how to measure their own weight, pulse and oximeter readings in their own homes which was monitored weekly by the practice nurse. Patients were given mobile telephone numbers for direct access to the COPD lead GP and the practice nurse. Any concerns were then passed to the COPD community team. The practice gave us examples of patients that had previously had recurrent excacerbations and had been frequest users of hospital services. Since being part of this programme and taking an active part in their asthma management they had had no hospital attendances.
- The patients' group organised a Saturday morning Health Check event every other year where patients could attend and take advantage of a free NHS health check. Invitations were sent to 145 patients who had not attended the practice for over five years and those that had not responded previously for an NHS health check.Other service providers such as Mcmillan, Carers

Good

Are services responsive to people's needs?

(for example, to feedback?)

Resource, Alzheimers Society, MIND and CIRCLE (a befriending support group for isolated patients) were invited and offered information, support and guidance. 79 patients had attended the last event where:

- seven patients were identified who had significantly raised blood pressure, of which two were in need of urgent care and were admitted to hospital and five were considered hypertensive and required treatment. The practice told us that managing these patients would reduce their risk of cardiovascular disease (CVD) and stroke.
- a number of patients were identified as having raised cholesterol readings. They were given advice and follow up appointments arranged.
- four patients were found to be at high risk of developing CVD. They were started on appropriate treatment and given dietary advice.
- several patients had raised blood sugars on the day and three were subsequently confirmed as being pre-diabetic and now undergoing regular monitoring.
- one patient had a history which was suggestive of asthma which was confirmed soon after the event and relevant treatment started.

The practice told us that identifying these conditions would have a significant positive effect on the patients future health and reduce the use of hospital services. Every patient that attended was given a goody bag which included health related gadgets and puzzles or small toys for children. They were all entered into a draw where the prize was a £50 voucher from a local supermarket.

- One of the GPs had a special interest in diabetes and had redesigned the service offered by the practice. The number of diabetic patients had been increased from approximately 400 four years ago to 838 to date. The advanced nurse practitioner and the trainee GPs were trained to run a number of weekly clinics, other training sessions were held for wider practice members resulting in a more opportunistic management of patients, that would not engage formally, could be undertaken. The practice had developed their own templates to capture all the information required. Care plans for all patients were being developed as they were reviewed and young diabetics were targeted for engagement including women of childbearing age.
- The practice nurse was attending a Mcmillan course called Living with Cancer. This meant that all patients in this group would have a care plan and would be offered more than medication, such as being signposted to weight, smoking and activity advice and signposting them to family support, counselling services and to what benefits may be available.
- The practice held a register of patients with a fatty liver. These patients were screened and reviewed annually.

Families, children and young people:

- 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice offered a comprehensive contraceptive service which included implants, depo injections, intrauterine devices and emergency contraception.
- All staff had received paediatric basic life support training.

Working age people (including those recently retired and students):

- The needs of this population group 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, extended opening hours and some Saturday appointments.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Patients were able to book appointments and order prescriptions online.
- Patients were able to use the electronic prescription service where they could nominate a pharmacy where the GP sends repeat prescriptions to, making the whole process more efficient and convenient for them. 60% of patients were now using this service.
- Receptionists were trained to signpost patients to the right person at the right time across a variety of health services.
- The patients' group organised a Saturday morning Health Check event every other year where patients could attend and take advantage of a free NHS health check. Invitations were sent to patients who had not attended the practice for over five years and those that

Good

Are services responsive to people's needs?

(for example, to feedback?)

had not responded previously for an NHS health check.Other service providers such as Carers Resource, Alzheimers Society and MIND and CIRCLE (a befriending support group for isolated patients) were invited and offered information, support and guidance. 80 patients had attended the last event where patients were identified who had high blood pressure, high cholesterol readings and other concerning symptoms. Some were treated on the spot and other referred for future treatment. Every patient that attended were given a goody bag which included health related gadgets and puzzles or small toys for children. They were all entered into a draw where the prize was a £50 voucher from a local supermarket.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Longer appointments or home visits were offered to patients according to their needs.
- Fast track appointments were offered to distressed patients to minimise time spent in the waiting area.
- The practice provided care to a local residential facility for adults with complex psychiatric needs.
- The practice employed a community nurse practitioner who carried out home visits to carry out health reviews, blood tests and health screening to its vulnerable patients who were unable to leave their homes.
- The practice had a number of leaflets and the practice survey translated into other languages for patients whose first language wasn't English.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Longer appointments were available where needed
- Annual reviews were offered to patients with complex mental health needs with care plans drawn up when appropriate.
- GPs proactively screened for dementia.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above local and national averages. This was supported by observations on the day of inspection and completed comment cards. 282 surveys were sent out and 124 were returned. This was a return rate of 44% and represented about 1% of the practice population.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 72% of patients who responded said they could get through easily to the practice by phone; CCG average - 61%; national average - 71%.
- 91% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG average - 79%; national average - 84%.
- 92% of patients who responded said their last appointment was convenient; CCG average - 77%; national average - 81%.
- 88% of patients who responded described their experience of making an appointment as good; CCG average - 68%; national average - 73%.
- 84% of patients who responded said they don't normally have to wait too long to be seen; CCG average - 66%; national average - 64%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The complaint policy and procedures were in line with recognised guidance. We reviewed several complaints that had been received in the previous year and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. The practice updated its registration of new patients policy to reflect current guidance from NHS England.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Staff were trained in the practice recruitment and selection process and were included in the interview panel when selecting new members of the team.
- All staff were considered valued members of the practice team. They were given protected time for professional development and for clinical staff, evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff teams.
- The practice had 6th form students who were interested in working in the NHS attached to the surgery who had then successfully gained admission to medical school in the last 12 months.
- The practice hosted an Eritrean doctor on behalf of Rochdale Northwest which is a charity that helps integrate refugees into the NHS. The practice are waiting for their next placement.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- All prescriptions that were collected from the surgery either by the patient, a family member or a pharmacy were signed for and the clinical system marked up and coded appropropriately. Those prescriptions that had not been collected were coded on the clinical system which enabled the practice to carry out a full audit of all prescriptions and to identify any trends and problems.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had signed up to the Rochdale Health Alliance Homelessness project and had donated flu vaccine for homeless people not registered with a GP. Members of the practice had volunteered to become part of the Homeless Outreach Service.
- The patient group were hoping to introduce a befriending service which is being rolled out by North

Are services well-led?

Good

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West Ambulance Service. The project is aimed at patients who are frequent 999 callers. The aim is to reduce 999 calls and alert key agencies to the needs of patients.