Hopwood Medical Centre

Quality Report

Hopwood
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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?	Outstanding
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Hopwood Medical Centre on the 4 February 2015 as part of our comprehensive inspection programme. This was the practice's first inspection by CQC under its new methodology.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the 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 and people experiencing poor mental health (including people with dementia.

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

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

We saw several areas of outstanding practice including:

· The practice worked closely with the local community to promote health awareness.

Summary of findings

· There was an active programme of clinical audits at the practice. A review of eight audits demonstrated that the practice was both proactive and successful in achieving positive outcomes for patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

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Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Are services responsive to people's needs?

Good

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

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Joint working with midwives, health visitors and school nurses were in place.

Working age people (including those recently retired and students)

Good

Summary of findings

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various local and national support

Summary of findings

groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 28 CQC patient comment cards and spoke with four patients who were also members of the practice patient participation group and spoke with two other patients.

We spoke with people from different age groups and patients from different population groups, including young patients and with long term conditions. The patients we spoke with were highly complementary about the service. Patients told us that they were treated with respect.

Patients we spoke with told us they were fully involved in deciding the best course of treatment for them and they fully understood the care and treatment options that had been provided.

Patients told us that staff were always pleasant and helpful.

Patients told us waiting areas and treatment rooms were clean and maintained.

We looked at feedback from the GP national survey for 2013/2014. Feedback included; 94% of respondents would recommend this surgery to someone new to the area.

96% of patients found it easy to get through to the practice on the telephone

93.1% of patients rated their experience of making an appointment as good or very good

93.9% of respondents to the GP patient survey described their overall experience of their GP surgery as good or very good

98% of patients had trust in the GP they saw and 100% of patients had trust in the nurse they saw at the practice.

Outstanding practice

The practice worked closely with the local community to promote health awareness. They arranged and funded quarterly education events for patients including a paediatric asthma awareness session, a paediatric CPR & first aid course and an adult CPR course commissioned through the British Red Cross. They held fundraising events for a local hospice and held coffee morning events in the surgery to support national cancer charities.

A health assistant who had undertaken training in identifying and supporting patients with caring responsibilities was a designated carers advocate/ champion and had lead responsibility for providing information about support available to carers and recently bereaved patients.

Hopwood Medical Centre

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 advisor, a practice manager specialist advisor and an expert by experience.

Background to Hopwood Medical Centre

The practice is located in Heywood, in Lancashire and has registered patients from the Heywood, Middleton and Rochdale area and is responsible for providing treatment to approximately 5400 patients.

The practice team comprises four GPs, one male and three female. A practice nurse, an assistant practitioner and a healthcare assistant. Additionally there is a practice manager and four secretary/receptionist staff.

The practice operates from a single storey purpose built premise. All treatment rooms are located on the ground floor and a patient reception area is located to the front of the building. Access to the building is suitable for patients who use a wheelchair and there is a disabled toilet which also provides baby changing facilities. A hearing loop is located in the patient reception area for those patients with hearing problems.

The practice is open Monday to Friday between the core hours of 8:30am and 6pm with extended hours three evenings per week between the hours of 6:30pm and 7:15pm.

The practice operates an open surgery between the hours of 8.30am to 10:00am alongside pre bookable appointments for morning surgery. All afternoon appointments are pre-bookable along with slots available for on-line booking. All urgent appointment are seen on the day, with patients under the age of 5 years attending the open surgery being given priority.

The practice offers telephone consultations all day Monday to Friday and home visits are available for patients who are not well enough or physically able to attend the practice in person. Patients can make appointments by telephoning, on line booking or by calling in at the surgery.

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

The practice is an accredited GP training practice for qualified doctors training to specialise in General Practice.

When the practice is closed patients are directed to the out of hour's service provided by BARDOC an out-of-hours service.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the

Detailed findings

National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 February 2015. During our visit we spoke with a range of staff that included, GPs, practice manager, practice nurse and reception staff and spoke with patients who used the service. We reviewed CQC patient comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place that ensured the delivery of safe patient care. These included the review of incidents, health and safety concerns and complaints.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we found that the practice had been pro-active in identifying and raising child protection and safeguarding incidents and sharing concerns with partner agencies, including contacting the local social services department and the police.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

The practice worked closely with Heywood, Middleton and Rochdale Clinical Commissioning Group.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were discussed at monthly member development meetings or more frequently when required. Significant events were a standing item on the members development programme. There was evidence that the practice had learned from the review of significant events. Processes ensured that significant events analysis was carried through until a satisfactory outcome was concluded and actioned and findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

From the review of compliant investigation information, we saw that the practice manager and GP partners ensured complainants were given full feedback in response to their concerns and given an apology and informed of any actions taken.

We saw evidence that the practice responded to NHS patient safety alerts, for example, medication alerts. The practice received regular safety information from organisations such as National Institute for Health and Care Excellence (NICE) and took action in response to safety alerts. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice manager and the lead GPs ensured that all staff were made aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding, practice staff had completed training in safeguarding children and adult protection at level two and GPs were training to level three. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to

recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice followed Rochdale Council safeguarding policy and protocol. There were flow charts positioned in staff work areas so staff understood what action and who to contact should they have concerns about a child or an adult.

One GP at the practice took lead responsibility for safeguarding and staff we spoke with knew they could approach the lead GP and or any other GP at the practice if they had concerns about a patient. The lead was knowledgeable about the contribution the practice made to multi-disciplinary child protection work. Arrangements were in place to share safeguarding concerns with NHS and local authority partners and this ensured a timely response to concerns identified.

We saw a record of events that had occurred in the last 12 months. We saw evidence of action taken as a result for example, the practice manager had alerted the local child protection team and other partners involved in safeguarding.

Within the patient record system there was an alert system which alerted GPs, nursing staff and reception staff to any ongoing child protection issues. When safeguarding concerns were raised staff ensured these alerts were put onto the patient's electronic record. Systems were in place to monitor children or vulnerable adult's attendance at Accident and Emergency or missed appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Patients we spoke with were aware of this service but none had direct experience of it.

Medicines Management

The practice had medicines management policies in place. The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) who visited the practice quarterly to review prescribing trends, for example, for antibiotics and Benzodiazepines. . The practice did not store controlled drugs. We saw that emergency drugs were safely stored and regular stock audits were undertaken and records maintained.

The practice stored vaccinations in a refrigerator. Systems were in place that ensured that vaccines were stored correctly. These included daily checks of temperatures of refrigeration. Checks of vaccine ensured that the stock was in date. Stock count and rotation of stock took place on vaccines and other medicines. Records of checks were maintained. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

GPs re-authorised medicines for patients on an annual basis or more frequently if necessary. Patients who received repeat prescriptions were

alerted to book in and arrange a medicine review. All repeat prescriptions were reviewed on a regular basis and only undertaken by clinicians. Patients we spoke with confirmed they had attended the practice for medicine reviews with a GP.

We saw prescriptions for collection were stored behind the reception desk. At the end of the day uncollected prescriptions were locked away in a secure cabinet. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. Patients were asked to confirm their name and address when collecting prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness & Infection Control

Patients we spoke with told us the practice was 'always clean and tidy'. We saw that the practice was clean throughout and appropriately maintained.

We saw that all areas of the practice were very clean and processes were in place to manage the risk of infection. Treatment rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities with posters promoting good hand hygiene displayed.

We found the practice had a comprehensive system in place for managing and reducing the potential for infection. There was an up-to-date Infection Control Policy in place. We saw updated protocols for the safe storage and handling of specimens and for the safe storage of vaccines.

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

The practice had procedures in place for the safe storage and disposal of sharps and clinical waste. We saw sharps boxes in clinical areas and clinical waste bins were foot operated.

We looked at staff training records and saw that all staff at the practice both clinical and non-clinical had completed training in infection control.

The practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

A GP at the practice took lead responsibility for infection control.

Equipment

Arrangements were in place that ensured all equipment used on the premises was well maintained. A defibrillator and oxygen were available for use in a medical emergency. These were stored in easy reach in the event of a medical emergency. Records of tests of the equipment were in place.

We found that arrangements were in place which ensured the safety and suitability of the building, for example tests of electrical installation, including portable appliance testing (PAT) of electrical equipment.

Good

Are services safe?

The practice manager had contracts in place for annual checks of fire extinguishers and portable appliance testing. Fire safety checks were in place and the practice was in the process of arranging a full fire drill to take place within the next month. All staff had received training in fire safety and there was information in the reception and patient waiting area to advise patients what action to take in the event of a fire.

Panic buttons were located in clinical and treatment rooms for staff to call for assistance in the event of a difficult situation and there was an alert facility with the EMIS web system which staff could use to raise and alert if they were in a difficult situation.

Staffing & Recruitment

The practice operated a recruitment and selection process which ensured that only suitable applicants were employed. The majority of staff had been employed at the practice for over three years. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

As part of the quality assurance and clinical governance processes checks of the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists were made to ensure that doctors and nurses continued to be able to practice.

Safe staffing levels were maintained. Three GPs provided a service to patients. There were four receptionists, a practice nurses, a healthcare assistant and a practice manager. Collectively the staff team were more than able to meet the needs of the patient population who were registered at the practice.

The practice manager and lead GP oversaw the rota for clinicians and this ensured that sufficient staff were on duty to deal with expected demand including home visits and daily patient demand for appointments including emergencies.

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. This ensured adequate staffing levels were maintained at all times and this included that ‘ad-hoc’ use of locums for holiday periods. The practice used a small bank of locum GPs whose work they were familiar with.

Monitoring Safety & Responding to Risk

Staff were trained in fire safety, basic life support and infection control. Staff knew where the emergency equipment was stored and how to access this quickly in the event of an emergency.

A review of practice minutes confirmed that safety and risk was monitored and discussed routinely at monthly practice meetings and weekly clinical meetings were GPs discussed patients who had been admitted to hospital as an emergency. This meeting also provided an opportunity for peer review and to discuss patients with complex care needs.

The practice had systems, processes and policies in place to manage and monitor risks to patients,

Good

Are services safe?

staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings, for example, safeguarding concerns and sharing information in a timely way with other agencies.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. A detailed business continuity plan was in place to deal with a range of emergencies that might impact on the day to day operation of the practice, for example, power failure, reduced staffing and access to the building.

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Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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The practice had an up-to-date fire risk assessment. We found that tests to fire alarms systems and other fire safety equipment were done on a regular basis.

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Staff were sufficiently trained to deal with medical emergencies. Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment.

The Practice has a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

Patients were aware of how to contact the out of hours GP service and the practice website had provided updated information for patients on this facility.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided a service for all age groups including older people, people with learning disabilities, children and families, people with mental health needs and to the working population. We found GPs and nursing staff were familiar with the needs of each patient and the impact of local socio-economic factors on patient care.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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

Clinicians proactively case managed and completed long-term monitoring of patients' needs. The practice held clinical meetings where all patients on the palliative care register were discussed. Clinicians we spoke with were familiar with, and were following current best practice guidance.

Practice nurses managed range of clinics, for example, asthma clinics, diabetes clinics and chronic obstructive pulmonary disease (COPD) reviews. The practice held a register of patients who had a learning disability and these patients were called for annual health checks.

The QOF provided evidence the practice were above local and national averages when responding to the needs of people with dementia, including those newly diagnosed with dementia. For those patients with dementia 83.1% had their care reviewed in a face-to-face review in the preceding 12 months. For patients with poor mental health data showed 96.3% of those diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the records.

Management, monitoring and improving outcomes for people

There was an active programme of clinical audits at the practice. A review of eight audits demonstrated that the practice was both proactive and successful in achieving positive outcomes for patients.

The practice showed us eight clinical audits that had been undertaken in the last two years. All of which demonstrated changes and improvements in outcomes. Some of the audits had been triggered by drug alerts issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) and others looked at the prevalence and aftercare of issues around heart failure, UTI and osteoporosis. These all demonstrated a questioning approach by the practice. Audits showed areas of improvement were actioned and discussed at a practice clinical meeting and where appropriate re-audited. Five of the audits reviewed contained two cycles of data collection with improvements in practice seen in the second data collection. Audits reviewed include in February 2013 a 'two cycle' audit of antibiotic prescribing that demonstrated improvements in outcome. In October 2012 an audit was completed in response to a drug alert, and involved identifying patients whose treatments needed modifying and in June 2013 a two cycle audit was completed in respect of the prescribing of Citalopram, this followed a drug alert and a second cycle demonstrated action was taken.

The practice was proactive in contacting patients who had missed annual reviews, to ensure they attended

appointments. A patient recall system was in place for patients with chronic health conditions which provided on going monitoring of patients conditions. This included patients receiving treatment for asthma and COPD.

Patients told us that GPs discussed and explained the potential side effects of medication during consultations.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma and heart failure and were above the local CCG average and the average for England. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 98.6% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 100% of outcomes achieved.

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Staff had access to training, the majority of which was completed through e-learning. The practice manager kept a record of all training carried out by clinical and non-clinical staff to ensure staff had the right skills to carry out their work. From our discussions with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

Staff told us they were able to access training and received updates when required. We saw staff had completed mandatory training in safeguarding children and adults, health and safety, infection control, equality and diversity, basic life support, confidentiality and fire safety. Some staff had completed chaperone training. The practice manager and lead GP were aware of the importance for staff across the practice to have an understanding of the Mental Capacity Act 2005 and there were plans to provide this training for staff.

All staff had an annual appraisal. We found that one of the strengths of the practice was the informal supervision arrangements that were in place. Staff told us that GPs and the practice manager were supportive and approachable.

All GPs took part in yearly appraisal that identified learning needs from which action plans were documented. All of the GPs in the practice complied with the appraisal process. GPs are required to be appraised annually and every five years undertake a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, cervical cytology and prescribing for which she was fully trained to undertake.

Working with colleagues and other services

Strong team work, cooperation between clinical and nonclinical staff and an understanding and appreciation for each member's role in the day to day delivery of the service to patients was evident across the practice.

The practice worked with other agencies and professionals to provide continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Multidisciplinary health care meetings took place at the practice and involved other health and social care professionals, for example the practice health visitors and Macmillan Nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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

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

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

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

Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients also had the option of using local services through a 'local triage' service. This meant that patients could attend local hospitals and other venues to see specialists.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Information received from other agencies, for example accident and emergency or hospital outpatient departments was read and actioned by GPs on the same day. Information was scanned onto electronic patient records in a timely manner. Systems were in place for managing blood results and recording information from outpatient's appointments.

All staff were required to sign a confidentiality agreement as part of their terms and conditions of employment at the practice. Staff fully understood the importance of keeping patient information in confidence and the implications for patient care if confidentiality was breached.

Consent to care and treatment

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations.

GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. One GP partner demonstrated a good knowledge, application and use of best interests meeting, for example, a patient who lacked capacity but was refusing medication. The GP had involved carers and family as part of the process.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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

There was a practice policy for obtaining and documenting consent for specific interventions. It was the practice that for the majority of treatments patients gave implied or informed consent and arrangements were in place for parents to sign consent forms for certain treatments in respect of their children, for example, child immunisation and vaccination programmes. Where patients were under 16 years of age clinicians considered Gillick guidance.

All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted.

Health Promotion & Prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. All new patients were offered an initial health check with the practice nurse when a new patient assessment was completed; this included a review of the patient's lifestyle including family medical history and a review of their smoking and alcohol activity. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

Where it had been identified that patients who needed additional support, the practice was pro-active in offering additional help, for example, smoking cessation and diabetes support. Practice nurses also ran a number of chronic diseases clinics including Chronic Obstructive Pulmonary Disease (COPD) and diabetes clinics.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders.

The practice kept a register of all patients with a learning disability and patients were offered an annual physical health check.

We saw a range of written information available for patients in the waiting area, on health related issues, local services and health promotion and carer's information.

The practice also supported patients to manage their health and well-being. This included national screening programmes, vaccination programmes and long term condition reviews.

The practice also provided patients with information about other health and social care services such as carers' support.

A health trainer visited the practice fortnightly and provided support and advice on a number of 'health promotion' issues. These included smoking cessation, reducing alcohol consumption, weight loss and exercise advice.

The practice arranged and funded quarterly education events for patients. Events organised for 2015 included the following: a paediatric asthma awareness session, a paediatric CPR & first aid course and an adult CPR course commissioned through the British Red Cross and awareness sessions from Age UK during flu season.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed staff speaking with patients respectfully throughout the time we spent at the practice. We observed reception staff speaking to patients in a respectful way and we heard staff during telephone discussions also speaking in a courteous manner.

Facilities were available within the surgery and upon request for patients who wanted to speak in private. It was normal practice that telephone calls would be transferred to the back office if more personal patient information was required.

A large proportion of CQC patient comment cards we received indicated that patients had been treated with dignity and respect by all staff employed at the practice.

We looked at a sample of consultation rooms, treatment rooms and clinical areas, all areas had privacy curtains to maintain patient dignity and privacy whilst they were undergoing examination or treatment.

The practice offered patients a chaperone service. Information about having a chaperone was in the waiting area. Staff we spoke with were knowledgeable about the role of the chaperone and only clinical staff undertook this role. Patients told us that they felt the staff and doctors effectively maintained their privacy and dignity.

We looked at 28 CQC comment cards that patients had completed as part of the inspection and spoke with six patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and patients told us GPs listened to them. Patients told us they were fully involved in decisions made about any treatments recommended.

We reviewed the most recent data available for the practice. This included information from the national patient survey 2013-2014 and a survey completed by GPs at the practice who had given surveys to 60 patients, 54 of whom were completed and returned. The evidence from these sources showed patients were satisfied with how they were treated. Data from the national patient survey showed that 100% of respondents had confidence and trust in the last nurse they saw or spoke to.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in all consultation rooms with the exception of one treatment room. We asked the practice to provide curtains in this room to ensure patient privacy.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Telephones in the reception area were located away from the reception desk and shielded by glass partitions. However patients reported that when sitting in the reception area it was easy to overhear conversations between reception staff and patients booking in. The reception desk and patient seating areas are small and located close to each other. We discussed this feedback with the practice lead and the practice manager who said they would review the arrangements in this area and see what improvements could be made to uphold patient confidentiality.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients understood their care including the arrangements in respect of referrals to secondary care appointments at local and other hospitals and clinics.

Patients told us they were happy to see any GP at the practice. They told us that they believed the practice nurse and health care assistant were competent and knowledgeable about their health care issues, for example, support with and managing diabetes.

Patients told us they usually got to see the GP of their choice when they made an appointment and other patients said they were happy to any of the GPs at the practice as they believed they were all 'good.'

Staff were knowledgeable about how to ensure patients were involved in making decisions. Care plan meetings were held monthly where GP, nursing staff and the practice manager reviewed the number of patients who had a care plan and those that were due for review. We were told that on the 30/12/2014 265 patients at the practice had a care plan. Care plans included, for example, the management of asthma and the management of depression. Care plans were signed by patients and a GP. Staff told us they understood and considered the requirements of the Mental Capacity Act 2005 where issues around capacity. Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions. Where required independent translators were available by phone for patients where English was their second language.

We noted where required, patients were provided with extended appointments to ensure GPs and nurses had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs were aware of local carer support groups that could be beneficial to carers registered with the practice.

Notices in the patient waiting room, and patient website also told patients how to access a number of carer support groups and organisations. A health assistant who had undertaken training in identifying and supporting patients with caring responsibilities was a designated carers advocate/champion and had lead responsibility for providing information about support available to carers and recently bereaved patients. The practice had worked with the local CCG to increase the numbers of patients/carers registered with the practice. This was a national initiative and we were told that Hopwood Medical Centre had 'met their targets.'

Staff told us that if families had suffered a bereavement, their usual GP would contact them.

Patients who were receiving care at the end of life had been identified and joint arrangements were in place as part of a multi-disciplinary approach with the palliative care team. GPs contacted the partners of recently bereaved patients to provide support and guidance where needed. Patients could be referred to counselling services if this was thought appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw evidence of service planning and the provision of appropriate services for different groups of patients. The GP partners had a good understanding of their patient population responded to patient need. There was good evidence of continuous review services by partner GPs to ensure services met patients' needs and preferences.

The practice offered a range of specific clinics through the GP and nurse appointment system, including diabetes reviews and COPD, (chronic obstructive pulmonary disease) reviews. Patients told us that their health needs were met whilst attending GP consultations and or nurse consultation.

There was evidence that the practice undertook more frequent chronic disease reviews and analysing the current QOF statistics the practice had totals all above the national average across a wide variety of chronic disease management indicators including Asthma and smoking cessation.

The practice was proactive in making reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments.

The surgery operated an electronic prescribing service. This enabled prescribers to send prescriptions electronically to a local pharmacy of a patient's choice.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). As a result of patient feedback larger door signs had been fitted to treatment rooms making it easier for patients to identify which room they were to attend.

Tackling inequity and promoting equality

The practice worked closely with a local initiative called 'Recovery Republic', where members of staff from the practice provided cover at volunteer sessions. Services and sessions covered included support for patients with mental health problems, support at domestic violence and abuse groups, support for patients experience pain, diabetes, eating disorders, alcohol and substance misuse issues and bereavement.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. Patients' electronic records contained alerts for staff regarding, for example, patients requiring additional assistance in order to ensure the length of the appointment was appropriate.

The practice provided home visits for those patients who were too ill or frail to attend in person. GPs provided telephone consultations and extended appointments were made available for any patient who required additional time.

We saw that the building was suitable for people who used a wheelchair. Disabled toilet facilities were shared with baby changing facilities. The entrance to the practice had level floor access and was suitable for wheelchair users.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

A small car park was located to the front of the building with off road parking available in nearby streets.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The practice had a population of 98% English speaking patients though it could cater for other different languages through translation services. Two of the GPs spoke Punjabi and Urdu.

Access to the service

Patients could access appointments by telephone, calling into the surgery and on line via the practice website.

Patients were very satisfied with the appointments system. They told us this was because the practice ran an open surgery five mornings a week between the hours of 8:30 and 10:00am. This arrangement was hugely successful with patients. Patients told us they appreciated being able to attend the practice when ill and without an appointment in the knowledge that they would be seen by a GP. Waiting

Good

Are services responsive to people's needs?

(for example, to feedback?)

times in the open surgery were not an issue for patients we spoke with. On the day of our inspection we observed a very busy and well attended open surgery. The practice also ran a pre-bookable appointment system throughout the day. Patients told us they usually got to see the same doctor.

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

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to six local care homes and the practice was responsible for providing care and treatment to 40% of patients who were resident in local care homes. GPs scheduled into their working day visits to patients in care homes on a daily basis.

Patients we spoke with told us they were very satisfied with the appointments system. They told us this was because the practice ran an open surgery five mornings a week between the hours of 8:30 and 9:30am. This arrangement was hugely successful with patients. Patients told us they appreciated being able to attend the practice when ill and without an appointment in the knowledge that they would be seen by a GP. Waiting times in the open surgery were not an issue for patients we spoke with. On the day of our inspection we observed a very busy and well attended open surgery. The practice also ran a pre-bookable appointment system throughout the day. Patients told us they usually got to see the same doctor.

Listening and learning from concerns & complains

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. The practice manager was mindful to respond and deal with patient's complaints as they arose in an attempt to avoid complaints escalating.

The practice had a complaints policy and procedure, which explained how the practice responded to complaints and compliments from patients and their representatives.

We saw that information was available to help patients understand the complaints system detailed in the practice information booklet and on the practice website. Patients we spoke with told us they knew how to make a complaint. They told us they felt comfortable about making a complaint and they were confident their complaint would be dealt with fairly. A patient told us that if they had any concerns they felt confident to approach the GP or practice manager in the first incident to resolve their issues before escalating their concerns more formally through the complaints process. None of the patients we spoke with had ever needed to make a complaint about the practice.

We saw that all complaints were logged and investigated by the practice manager who consulted with GPs and or nursing staff where relevant. We saw that the provider responded to complaints' in a timely manner and had taken action to resolve their complaints.

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 around patient care. Staff we spoke with knew that the practice was committed to providing good quality primary care services for all patients, including the management of long term health conditions.

We saw evidence that demonstrated the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people.

There were plans in place to facilitate the ongoing development of the practice which included the development and availability of telephone consultations for patients and the development of 'Skype' consultations for patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw where these had been updated they were comprehensive and reflected up to date guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles, for example, one GP was lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had systems to identify, assess and manage risks related to the service including health and safety issues. Systems were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. These included monthly practice meeting and weekly peer review meetings that were attended by clinicians.

The use of clinical audits was firmly embedded across the practice and results were reviewed and used to plan for patient care. The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Learning from significant events took place and SEAs were discussed at practice meetings.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to monitor services and record performance against the quality and outcomes framework.

The practice manager attended a local practice manager's forum on a monthly basis. This

provided her with the opportunity to review how the service was performing in comparison to other GP practices across the Rochdale area

Leadership, openness and transparency

We observed that leadership was clearly visible across the practice and with well-established lines of accountability and responsibility.

The staff group was stable one. Staff told us they enjoyed their work and they felt supported and there was good team work across the practice.

Information sharing arrangements were good and each member of staff's contribution was valued. Staff told us they would feel comfortable speaking with the registered provider or the practice manager should they have any concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy and disciplinary procedures, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice worked closely with its local community and held fundraising events for a local hospice an held coffee mornings for Marie Curie and McMillan Cancer Support.

The practice worked closely with its local high school. The practice had run a competition and asked pupils to submit paintings of the practice. The practice displayed a canvas painting that had been completed by one of the pupils.

Are services well-led?

Good

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

The practice had a patient participation group (PPG) which met quarterly and currently had 17 active members. The PPG included representatives from various population groups; retired people and older people. The practice manager chaired the PPG and there were plans and hopes that a patient member would take over this role.

We met with four members of the group who told us the overall aims of the group were to support patients, improve outcomes for patients and to challenge the practice on behalf of patients. Two members of the group were proactive in their attempts to support the return of a sight clinic to the area and were actively campaigning on behalf of other patients.

We were told that there were plans to set up a practice led walking group to help patients and staff to loose weight and keep fit-physically and mentally

GPs at the practice who had given surveys to 60 patients, 54 of whom were completed and returned. The evidence was reviewed and showed that 60% of patients rated 'satisfaction with the doctors caring and concerned' as 'excellent', 20% rated 'very good'. Similarly feedback on how patients were treated by receptionists was reported as, 57% excellent and 33% as 'very good.'

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

Management lead through learning & improvement

The provider had systems in place to review incidents referred to as 'significant events analysis' (SEA).

Quality assurance arrangements at the service ensured that performance was reviewed regularly.

These included periodical reviews of clinical performance data provided by the local clinical commissioning group.

Other audits included a monthly drug stock take, a review of NHS health checks and of the corresponding patient groups who had attended.

NHS patient safety alerts, for example, medicine alerts, were shared with staff.

Annual appraisal and supervision arrangements were well developed and established across all staff groups.

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at four staff files and saw that training had been recorded and appraisals had taken place. Staff told us that the practice was very supportive of training and continuing professional development.

The practice was a GP training practice, and was an accredited GP training practice by the north west deanery of postgraduate medical education.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan.

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