

The Alastair Ross Medical Practice

Inspection report

Brightmet Health Centre,
Brightmet Fold Lane, Brightmet,
Bolton
Lancashire
BL2 6NT
Tel: 01204 463 800

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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 location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall. (Previous rating April 2016 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at The Alastair Ross Medical Centre on 4 December 2018 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 had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role.
- 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.

- GPs were actively engaged with the Bolton Integrated Neighbourhood Team so they were aware of health care trends in the Bolton area. They also held regular multi-disciplinary meetings to discuss individual patient's health care to ensure they received the care and support they needed.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they could access care when they needed it.
- The practice organised and delivered services to meet patients' needs. It took account of patient individual needs and preferences so they received the right care and treatment.
- Leaders had the capacity and skills to deliver high-quality, sustainable care. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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	

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

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Background to The Alastair Ross Medical Practice

The Alastair Ross Medical Centre provides personal medical services to 7034 patients within the NHS Bolton Clinical Commissioning Group (CCG) area. Services are provided from: Brightmet Health Centre, Brightmet Fold Lane, Bolton, Greater Manchester BL2 6NT

The practice website is:

Information taken from Public Health England placed the area in which the practice is located as number one 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.

The out of hours provider is Bury and Rochdale Doctors on Call (BARDOC).

There are four GPs working at the practice (three males and one female). All the GPs are partners of the practice. The GPs are supported by a team of clinical staff including; four practice nurses and an assistant practitioner. There is an administration team which comprises of two practice managers and a team of reception / administration staff.

The practice regulated activities are:

Family planning

Treatment of disease, disorder or injury

Maternity and midwifery services

Diagnostic and screening procedures

Surgical procedures

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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 including sepsis.

- 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.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Are services safe?

- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Following the inspection, we were told that a newly devised system and template to log safety alerts was in place with information being available for all staff to view.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and all of the population groups 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 and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Appointments could be booked by phone or on line and flexible appointments were available as necessary. For example, longer appointments for patients with complex needs.
- All staff were trained in adult and child safeguarding procedures. There was a safeguarding policy and a dedicated safeguarding noticeboard for staff.
- GPs were actively engaged with the local Integrated Neighbourhood Team so they up to date with healthcare trends in the Bolton area.
- GPs met regularly with other health care professionals to ensure patients received the care they needed.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Patients had a named accountable GP who co-ordinated their care.
- GPs had a good working relationship with health care professionals within the area.

- Flu, shingles and pneumonia vaccinations were given.
- A member of staff was the carers lead. They had responsibility for providing carers with information about the services available to them along with an information pack and details about the Bolton carers support service.
- There was a dedicated telephone line for nursing and residential home staff.

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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension). NHS health checks were available for early identification of chronic diseases.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.
- There was a clinical lead GP for all major conditions.
- Patients considered at risk of hospital admission were given a dedicated surgery telephone line to discuss their health care needs.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Are services effective?

- GPs held a three monthly multi-disciplinary safeguarding meeting and regular meetings were held with the outreach midwife team.
- Health promotion campaigns were held.
- Sexual health screening was available including chlamydia screening.
- Contraception advice was available including coil and implant fitting.

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

- The practice's uptake for cervical screening was 70%, which was below the 80% coverage target for the national screening programme. However, this was in line with the Bolton Clinical Commissioning Group average of 73% and the national average of 72%.
- The practice's uptake for breast and bowel cancer screening was in line with local and national average.
- The practice had systems to inform 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.
- Nurse appointments were available from 8 am to 6.30 pm and a phlebotomy service from 8 am.
- Referrals were made to other services for lifestyle advice including mental health services, drug and alcohol services and smoking cessation.
- Minor surgery facilities were available at the practice.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental

illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication. Physical health reviews were arranged during a home visit when needed.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. Ad-hoc dementia screening was also available for patients at risk of this illness.
- The practice offered annual health checks to patients with a learning disability.
- The practice's performance on quality indicators for mental health was in line with local and national averages.
- Patients' carers were offered an annual health check and provided with information about services available to them.

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. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraception.

Are services effective?

- 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. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- 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 considered 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 need 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- 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. In the light of this, patients were encouraged and supported to managing their own health care issues alongside any medical interventions. Patients could refer themselves to the practice health improvement practitioner (employed by the Bolton Clinical Commissioning Group) who provided them with information and advice about how to manage their care needs and stay healthy.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people 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 carers and supported them.
- The practice's GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

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

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.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- 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 provided effective care coordination for patients who were more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- There was a flexible appointment system. For example, longer appointments were available for patients that needed them and appointments were provided at quiet times of the day for patients who become anxious.
- Referrals were made to the health improvement practitioner who gave information and advice on how patients could manage their conditions themselves and stay healthy. Patients were also referred to the local pharmacist for advice on smoking cessation.
- Patients were offered an appointment when they had attended A and E but this visit was deemed to be inappropriate.

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 practice nurse also accommodated home visits for those who had difficulties getting to the practice on a case by case basis.

- A medicines delivery service could be arranged for housebound patients. Dosette boxes were provided to patients with complex needs to help them manage their medicines more easily. This was arranged through the pharmacy medicine delivery service.
- Housebound patients could order their medicines by post and on-line. Pharmacies and third parties can also order their medicines on their behalf.
- GPs visited patients registered with the practice but living in a nursing / residential care home. Patients were also assessed via Telemed (this is like a skype call) by a clinician not employed by the practice.

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 were provided with 24-hour blood pressure monitoring equipment.
- Patients were signposted to local support services so they had information about how to manage their own conditions at home.

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 12 were offered a same day appointment when necessary.
- On the day appointments / telephone consultations were available for children under 12 years of age.
- There was a system to follow up on children who did not attend appointments with secondary care services.
- Evenings, weekend and bank holiday routine appointments were available via the GP Federation Hub.

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

Are services responsive to people's needs?

- 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.
- Telephone consultations were available so patients did not have to take time off work
- Referrals were made to the practice health improvement practitioner for advice about drug and alcohol services and other local services available.
- Minor surgery facilities were available.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed address.
- Patients with a learning disability were offered an annual health check.
- Bereavement support information was available.
- Patients at risk of harm would only receive a weekly prescription of their medicines.
- GP follow up appointments were available for patients needing extra support.
- Staff worked with local community support services including the practice mental health practitioners, drug and alcohol services and the citizens advice bureau.

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.
- A mental health practitioner (employed by Bolton Clinical Commissioning Group) worked at the practice part time. Their role was to support patients with the mental health difficulties through an assessment of their care needs and discussion. Patients were referred to other services as needed. The mental health practitioner provided patients with information about local mental health services available to them and advice on how to manage their own mental health.

- Patients' medication was monitored regularly.
- Patients were given information about the Bolton single point of access team which provided support and assessment to patients experiencing a crisis with their mental health.
- Same day urgent appointments and GP telephone consultations were available.

Timely access to care and treatment

Patients could 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.
- Patients reported that the appointment system was easy to use.
- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Only one complaint was received in the last year, therefore no analysis of trends was possible.
- Verbal complaints were dealt with as they arose although they were not logged. We were informed after the inspection that a system had been set up for logging any future complaints.

Please refer to the evidence tables for further information.

Are services well-led?

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 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. The practice staff worked well and consistently with other agencies to provide a multi-disciplinary approach to patients' care.
- 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, sustainable care.

- The strategy was in line with health and social care 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.

- Leaders and managers acted on staff behaviours and performance when it was not consistent with the practice 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.
- 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.
- There was a strong emphasis on the safety and well-being of all staff.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

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. Practice leaders had oversight of safety 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 considered and understood the impact on the quality of care of service changes or developments.

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.
- 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.

Are services well-led?

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.
- 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.

Please refer to the evidence tables for further information.