The Olive Family Practice Ltd

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Olive Family Practice Ltd on 27 May 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes. For example, they did not have set appointment times and instead had devised a system using units of activity. This worked well due to the diverse needs of the patients, where interpreters were often required and often patients had complex needs.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example there was close contact with the local mosques.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

- The practice had good links with the local mosques.

Summary of findings

- GPs usually looked after the palliative care needs of their patients, and where it was anticipated they would be away from the practice another GP in the area was introduced to the family in advance to ensure continuity of care. GPs were contacted by religious leaders or families when a death occurred and they attended in a timely manner to issue death certificates so a funeral could be arranged according to the patient's religious beliefs.
- Information within the practice was available in a variety of languages and staff also spoke several languages. The practice had established links with a nearby community centre that could provide translation services as some of the languages spoken by patients were not covered by the telephone translation service. For example, volunteers translated for the Oromo language. There were over 20 languages spoken by patients at the practice and a high proportion did not speak English as a first language so interpreters were required daily.
- The practice had a flexible appointments system, so instead of having set appointments they had units of activity in five minute blocks. They found this met the needs of the diverse practice population and reception staff had been well trained in how to determine the appropriate number of units of activity to allocate to a patient. For example, if translation services were required a patient was usually allocated 20 minutes, and five minutes was allocated to a telephone appointment. We saw an example of a non-English speaking patient with post-traumatic stress disorder being allocated 50 minutes.
- In response to demand during the winter months the practice had a walk-in surgery for a short time in the afternoons. They still directed patients to the pharmacy if this was appropriate but they found the open surgery was the most effective way of managing the needs of the patients and the time of the clinical and reception staff.

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 report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation. Learning was shared with all staff in the weekly practice meetings, and the practice manager tested the understanding of staff following them completing training, including on-line training.
- Information about safety was highly valued and was used to promote learning and improvement.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- Safeguarding procedures were well established and there was evidence of positive outcomes for patients where safeguarding concerns had been identified.
- GPs followed up vulnerable patients who failed to attend their appointments to ensure everything was okay.
- Regular medicines checks were in place, and GPs used electronic prescribing.

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 (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally. For example performance for diabetes related indicators was 93.1% (better than the local average of 88.7% and the national average of 89.2%) and performance for mental health related indicators was 100% (better than the local average of 93.9% and the national average of 92.8%).
- The practice arranged information sessions with patients to provide them with relevant information.
- Interpreters were arranged to ensure patients received an accurate message.

Summary of findings

- The practice manager monitored staff training. They also tested the knowledge of staff about relevant training during the weekly practice meetings. Staff told us they found this positive and helpful.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for almost all aspects of care. For example 94% of patients said the GP gave them enough time (above the CCG average of 88% and the national average of 87%), and 92% of patients said the last GP they spoke to was good at treating them with care and concern (above the CCG average of 87% and the national average of 85%).
- Feedback from patients about their care and treatment, in person during the inspection and on CQC comments cards was consistently positive.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. One example was a reception staff member making arrangements for a non-English speaking person to attend a more appropriate healthcare setting for their needs.
- Carers were identified on the practice's computer system, and totalled 2.2% of the practice list. Information for carers was available in the waiting room in English and Guajarati which was the second most common language. Annual health checks were offered to carers and 100% of registered carers attended for a health check in 2015-16. The GPs ensured direct support was given to carers to benefit the whole family holistically.
- GPs carried out end of life care for their own patients and they made arrangements to introduce a nearby GP to the family in advance if they were going to be away from the practice, for example on holiday. They usually attended the funerals of patients. They also had good links with the local mosques and Bolton Hindu Forum and were able to visit to issue death certificates when needed to ensure patients could arrange funerals in line with their religious beliefs.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.

Summary of findings

- The practice held a late afternoon open surgery during the winter months as an effective way of managing extra demand, particularly from parents collecting their children from the school next door. However, they directed patients to other services such as the pharmacy if this was more appropriate.
- The practice did not have set surgery times and these were flexible to meet the needs of patients. We saw that during the Ramadan period surgery times had changed as the practice knew from experience that not as many patients requested early appointments. The needs of staff who were fasting was also taken into account so the amended working and surgery times benefitted patients and staff.
- The practice had developed their own appointments system based on units of activity of five minutes each. Staff had received training, including scenario training, prior to the system being put in place so they were all aware of how long to allocate for varying patient needs. We saw an example of a patient requiring an interpreter being allocated 20 minutes and a patient with complex needs who also required an interpreter being allocated 50 minutes.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff during weekly meetings.

Are services well-led?

Outstanding ☆

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Reception staff told us they felt they were an integral part of the practice and they felt valued.
- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and looked at ways to holistically manage the different healthcare and social needs of their individual patients.

Summary of findings

- The practice kept real time data relating to the governance of the practice. They felt this was beneficial as it could be identified if staff had particular difficulties or where additional staff could be utilised if needed. They told us this had met with some resistance when it was brought in but now staff saw this as a positive tool to ensure the practice worked well.
- The lead GP had visited a healthcare organisation in Bradford to gain a greater understanding of how they managed their diverse practice population. They told us they tried to keep up to date with new models of care and were constantly looking at ways to improve the health outcomes for their patients.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. They recognised that a lot of older patients lived with their extended families so they involved carers where appropriate.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. They kept a record of housebound patients so visits could be easily arranged.
- Annual health checks were offered to patients over the age of 75. The practice had a low number of these patients and the majority had had a health check in the past year.
- GPs provided continuity of care to patients at the end of their lives, and if they had holidays planned they introduced new GPs to the families before they went.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long term conditions.

- The appointment system supported patients with varying needs so their long term condition reviews were allocated an appropriate amount of GP time.
- Care plans were in place for patients at risk of an unplanned hospital admission. We saw these were discussed at weekly practice meetings and at monthly multi-disciplinary team meetings. Care plans were also in place for all patients with a long term condition.
- GPs looks holistically at patients conditions to ensure they received the best outcome. They found patients often had multiple unmet needs and found taking extra time speaking to them during appointments identified issues relating to the patient as a whole.
- Performance for diabetes related indicators was 93.1%. This was better than the local average of 88.7% and the national average of 89.2%.

Families, children and young people

Outstanding ☆

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

Summary of findings

- 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 attended A&E. GPs followed up all children who had not attended a pre-booked appointment.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies. During the winter months when mothers made more demands on GPs the practice put on open surgeries in the late afternoon. They found this effectively met the demand while reducing pressure on the reception staff.
- We saw positive examples of joint working with midwives, health visitors and school nurses. A multi-disciplinary team attended meetings at the practice monthly.
- The GPs treated families in a holistic way. For example, they encouraged childhood immunisations by explaining the impact not having the immunisations could have on older members of the family.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding 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 open until 8pm one day a week. Telephone appointments were also available.
- 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.
- The practice invited patients over the age of 30 for the NHS health checks usually aimed at over 40s. They told us the high number of BME patients meant they were at greater risk of developing diseases such as diabetes, and they used this opportunity to diagnose earlier, stop signs of any deterioration in health and provide education to patients.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people who circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. We saw examples of homeless patients being registered at the practice and the practice manager told us they sought advice from the CCG if patients without an address requested they became a patient.
- The practice offered longer appointments for patients with a learning disability, and reception staff knew how long to allocate for appointments using their units of activity system.
- The practice had good safeguarding processes in places and we saw examples of close working with other agencies including the police while securing positive outcomes for patients.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- 94.74%of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the CCG average of 86.14% and the national average of 84.01%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in January 2016. The results showed the practice was usually performing above local and national averages. 398 survey forms were distributed and 99 were returned. This was a response rate of 25%, representing just over 3% of the practice's patient list.

- 88% of patients found it easy to get through to this practice by phone compared to the CCG average of 79% and the national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84% and the national average of 85%.
- 95% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 78% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards which were all positive about the standard of care received. Patients said staff were friendly and the GPs supportive. Patients commented that they were able to access appointments, they were always greeted with a smile, and they felt staff went above and beyond when providing assistance.

We spoke with seven patients during the inspection. All these patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. They told us they could access emergency appointments when needed, and felt included in decisions about their health and treatment. One patient told us the GP telephoned them to ask how they were feeling when they had been ill.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice had good links with the local mosques. This meant when required accurate healthcare messages could be given by religious leaders.
- GPs usually looked after the palliative care needs of their patients, and where it was anticipated they would be away from the practice another GP in the area was introduced to the family in advance to ensure continuity of care. GPs were contacted by religious leaders or families when a death occurred and they attended in a timely manner to issue death certificates so a funeral could be arranged according to the patient's religious beliefs.
- Information within the practice was available in a variety of languages and staff also spoke several languages. The practice had established links with a nearby community centre that could provide translation services as some of the languages spoken by patients were not covered by the telephone translation service. For example, volunteers translated for the Oromo language. There were over 20 languages spoken by patients at the practice and a high proportion did not speak English as a first language so interpreters were required daily.
- The practice had a flexible appointments system, so instead of having set appointments they had units of activity in five minute blocks. They found this met the needs of the diverse practice population and reception staff had been well trained in how to determine the appropriate number of units of activity to allocate to a patient. For example, if translation services were required a patient was usually allocated 20 minutes, and five minutes was

allocated to a telephone appointment. We saw an example of a non-English speaking patient with post-traumatic stress disorder being allocated 50 minutes.

- In response to demand during the winter months the practice had a walk-in surgery for a short time in the afternoons. They still directed patients to the pharmacy if this was appropriate but they found the open surgery was the most effective way of managing the needs of the patients and the time of the clinical and reception staff.

The Olive Family Practice Ltd

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and also included a GP specialist adviser.

Background to The Olive Family Practice Ltd

The Olive Family Practice Ltd is based in a large health centre on a main road approximately half a mile from the centre of Bolton. The practice is at ground floor level and is fully accessible to patients with disabilities. There is a car park at the rear of the practice.

The Olive Family Practice Ltd is an organisation and the lead GP is the director of the company. The practice is overseen by NHS Bolton Clinical Commissioning Group (CCG) and it delivers commissioned services under an Alternative Provider Medical Services contract. At the time of our inspection there were 3221 patients registered with the practice.

There are three GPs (two male and one female, 2.2 working time equivalent) and a regular female locum GP. There is also a practice nurse, a healthcare assistant, a practice manager and administrative and reception staff.

The practice is open daily from 8am until 6.30pm, with extended hours opening every Tuesday until 8pm. There were no set surgery times as these were flexible to meet the needs of patients.

Patients at the practice are from over 30 nationalities and over 20 languages were spoken by patients. Some of the languages spoken were not available on the telephone translation service. There is a higher than average number of patients in the 0 to 35 age group, especially in the age groups 0 to 4 and 25 to 29. There is a lower than average number of patients aged over 40, and a much lower than average number of patients aged over 65.

The practice is in the most deprived decile and patients have a lower than average life expectancy. The number of patients with a long term health condition is almost 20% less than the CCG and national average.

There is an out of hours service available provided by a registered provider, Bury and Rochdale Doctors on Call (BARDOC).

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 May 2016. During our visit we:

- Spoke with a range of staff including GPs, the practice nurse, the practice manager and reception and administrative staff.

Detailed findings

- Spoke with seven patients.
- Observed how patients were spoken with at the reception desk.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed a range of policies and procedures.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events

- Staff told us they completed a form to report significant events. This was then passed to the practice manager who discussed it with the staff member and transferred the information to an electronic format. Staff told us they had a low threshold on incident reporting and preferred to discuss all incudents where they felt changes could be made to improve outcomes for patients. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw that significant events were reviewed after three months to ensure incidents had not been repeated. We saw an example of a medicine error by a pharmacist. The practice managed this with the clinical commissioning group (CCG) so that they could improve training for medicine dispensers.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a significant event where there had been an error with patients' names, additional training was provided during a practice meeting. Significant events was a standing agenda item for the weekly practice meetings, so information was shared with all staff.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding. Safeguarding meetings took place at the practice quarterly and health visitors attended these on an ad hoc basis if required. The GP and health visitors followed up vulnerable patients, especially children, who had not attended a pre-booked appointment. They said they did this to ensure there were no concerns about the patients and their family, and also as a way of educating patients about the importance of attending appointments and the impact on the practice of patients not attending. We saw examples of cases being appropriately referred to the relevant agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3.
- We spoke with one patient who told us the practice had instigated a safeguarding referral for their family. They told us the practice had recognised a serious issue within their family and enabled them to turn their lives around.
- Following an incident of aggressive patient behaviour the practice introduced a patient charter. Patients signed this when they registered with the practice and it set out the responsibilities of patients and the practice. The practice manager told us they felt patients took this contract seriously and it made patients feel safer knowing the practice took abusive patients seriously.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Good

Are services safe?

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Administrative staff carried out regular searches to ensure patients' medicines reviews were up to date. Reception staff were not permitted to re-authorise medicines; only GPs could do this. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. All prescriptions were printed and the practice did not hold prescription pads. The serial numbers of prescriptions were logged when they were received at the practice and as they were used. The GPs usually used electronic prescribing following home visits so they did not need to take blank prescriptions with them.
- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. These included a full employment history being available for all staff, references being followed up, with verbal references being recorded, identity checks, and qualifications being checked. All staff had an up to date DBS check. The professional registration status of GPs and the practice nurse were checked annually and a record was kept of this check. These robust checks were also in place and recorded for locum GPs. The practice manager followed a checklist when recruiting new staff to ensure all the required pre-employment checks had been completed.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Some responsibilities, for example fire alarm testing, were those of the building managers. In these cases the practice held confirmation of which organisation was responsible for each area of safety, and where they were not the responsible body they kept confirmation relevant checks had been carried out.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. We saw that holidays were usually arranged approximately four months in advance so staff cover could be arranged. The practice manager worked part time, but another senior member of staff was always on duty if they weren't. The rotas ensured that at all times either the practice manager or the lead GP was on duty. We saw that arrangements for staffing were flexible to meet the needs of staff and patients. For example, during Ramadan they knew from experience that patients preferred to attend later in the day rather than at 8am when the practice opened. The GPs rotas were rearranged for the period of Ramadan, so that their individual preferences to manage fasting were considered and more appointments were available at the times patients preferred.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Good

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- There was a defibrillator available, kept in the community services reception on the same floor of the building as the practice. The practice was assessing the need for another defibrillator that would be kept at their practice. Oxygen was available with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.9% of the total number of points available. The practice's exception rate was 4.7%, which was below the clinical commissioning group (CCG) average of 7.8% and the national average of 9.2%. Exception rates ensure practices are not penalised, for examples when patients did not attend for a review or they cannot prescribe a certain medicine due to a side effect.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed:

- Performance for diabetes related indicators was 93.1%. This was better than the local average of 88.7% and the national average of 89.2%.
- Performance for mental health related indicators was 100%. This was better than the local average of 93.9% and the national average of 92.8%.

  There was evidence of quality improvement including clinical audit.
- There had been at least two clinical audits completed in the last two years where the improvements made were implemented and monitored. We also saw single cycle audits where a review date had not yet been reached.

  We saw a recently completed second cycle of an audit for prescribing a medicine for patients with chronic heart disease. This showed improvements in the prescribing of the medicine.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Information about patients' outcomes was used to make improvements. The lead GP told us the diversity of the practice population meant they had to adapt pathways to reach the desired outcomes. Patients often had several unmet needs and GPs tried to prioritise these looking holistically at the patients and their family members. They gave us an example of a patient who they tried to treat, but who would not attend appointments arranged for them at the hospital. By working with the patient they discovered the patient was unwilling to address other health issues identified by the hospital. With the patient's consent they involved other members of the family and found out more about the health beliefs of the family to make addressing the health issues easier.

The lead GP explained that they had researched the different needs of the cultural and religious groups in the area as they had different health outcomes and beliefs. They said there was a high proportion of households where three generations of a family lived together, and said the number of people in the area with chronic heart disease was rising. They had found that the older population did not understand the effects of diet on health. There was a high number of cheap fast food outlets in the area, and the GP was looking at innovative ways of addressing these issues and educating patients.

Patients with long term conditions had a care plan in place. We looked at several care plans and saw they were well constructed and completed, with evidence of patients being involved in the planning. Clinical templates were used to review patients' care, and the templates were devised to ensure care was evidence based. We saw these were working well. The practice held an avoiding unplanned admissions register. We saw that 47 patients (1.46% of the practice population) were on this register. They had a care plan in place and we saw these were discussed at the weekly practice meetings.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

All medicine reviews were carried out by a GP. Some medicines were available on repeat prescriptions and where this was the case the practice carried out regular searches to ensure all relevant blood tests were completed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality and we saw evidence of completed inductions.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. The practice nurse and healthcare assistant had regular updated training. For example, for those reviewing patients with long-term conditions and we saw evidence that training was up to date.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines demonstrated how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months and we saw evidence that further training was planned.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The practice manager recognised that during the weekly practice meetings they talked about e-learning that staff had completed. They regularly tested their knowledge to ensure the e-learning had been effective. Staff told us they found regular discussion about their understanding of training positive and helpful. They told us there was a strong emphasis of sorting out any challenging problems at the earliest opportunity and having weekly full team meetings meant their knowledge was kept up to date.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. When a GP referred a patient to another service or for an appointment the response was sent to that GP to ensure continuity of care. There was a buddy system in place so if a clinician was off another named clinician dealt with responses. We saw there was a low A&E attendance rate for the practice. All patients who had attended A&E or been discharged from hospital were spoken with soon afterwards and an appointment was made if required. GPs also reviewed daily the patients who had contacted the out of hours service.

Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. District nurses, health visitors and Macmillan nurses attended meetings at the practice quarterly. We saw an example of a best care meeting being arranged in-between the quarterly meetings for a newly diagnosed patient with cancer, and the GP told us they had an excellent relationship with the palliative care team. There was a named GP for palliative care. Prescription protocols were in place for palliative care medicines and they had medicine administration sheets ready in case palliative care medicines were required at short notice.

Consent to care and treatment

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. The lead GP had attended training in the Mental Capacity Act 2005, the Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS). Other GPs had also attended training. This training was cascaded in less detail for all staff during a practice meeting. The practice had one patient who was on a DoLS so they had made sure all staff were aware of what this meant.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice told us that drug misuse in the area was high. Alcohol use was also high but problems were less likely to be identified or acknowledged because of religious beliefs. The practice was looking at ways to engage with these patients. Referrals were made to Bolton Integrated Drug and Alcohol Services (BIDAS) and there was a support unit in the area.
- The practice nurse was able to offer weight management advice. A health trainer attended the practice once a week to offer holistic health advice. Where it was felt exercise would improve a patient's health they were offered heavily subsidised gym membership.

The practice's uptake for the cervical screening programme was 81.77%, which was comparable to the CCG average of 82.12% and the national average of 81.83%. The practice nurse usually telephoned patients who did not attend for their cervical screening test. The practice nurse told us the families of unmarried females who received a written invitation for a cervical smear test sometimes made attendance difficult as they did not understand the condition. They felt a telephone call to the patient helped this. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice nurse told us they spent time talking to female patients about the importance of cervical screening and telling them about the procedure in advance of their appointment. We saw they had visual information so they could show patients exactly what he procedure involved and they felt this helped patients during the procedure.

The practice had two homeless patients registered with them. They told us that often their homeless patients lived in a short term hostel in the area, and the CCG were very good at offering advice on how to register patients who did not have an address. This meant patients in this group good access all the facilities offered by the practice.

Childhood immunisation rates for the vaccinations given were lower than the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 62.5% to 85.9% and five year olds from 88.1% to 95.2%. The practice engaged with the local population to encourage vaccinations.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice had recognised that due to the ethnic diversity of the practice population some health issues, such as diabetes, were prevalent in younger patients. For the past 18 months the normal NHS health checks for patients over the age of 40 had been offered to patients aged over 30. Attendance rates were good and they felt that by offering these checks earlier some health problems could be better managed before they became more serious, and patients' education would also be improved. Appropriate follow-ups for the outcomes of health assessments and checks were made where abnormalities or risk factors were identified. The practice nurse also carried out health checks for patients over the age of 75. Housebound patients were coded on their computer system so they could visit them to carry out health checks as appropriate.

Health information leaflets and posters were available in the waiting room. Some posters also had information in Guajarati and we saw that some multi-lingual leaflets were available, for example for diabetes and strokes.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 35 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with seven patients. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us the GP telephoned them to see how they were feeling when they had been ill. Another told us the GPs listened to them and tried to sort out their problems.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was at or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.

Are services caring?

We saw notices in the reception areas informing patients this service was available. Patients spoke over 20 languages so the practice used a variety of interpreters, both face to face and on the telephone.

- Information leaflets were available in easy read format. Leaflets in other languages were also available.
- We saw evidence of patients being involved in their care planning. We saw health needs were looked at holistically as it was recognised that housing, financial issues and social isolation had an impact on the physical and mental health of patients.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Some of this was in languages other than English.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 70 patients as carers (2.2% of the practice list). The practice offered annual heath checks for carers and in 2015-16 100% of carers attended for a health check. The lead GP told us they proactively and with the consent of the patient involved carers in discussions about patients' care, especially as there were a lot of extended families living in the same household. GPs had found that patients living with extended families could have a lot of carers. They therefore ensured direct support was given to the carers to benefit the whole family holistically. Written information was available to direct carers to the various avenues of support available to them. There was a carers' noticeboard in the waiting area and information on the noticeboard was provided in English and Guajarati.

Staff told us that if families had suffered bereavement, their usual GP telephoned them and usually attended the funeral. A lot of patients lived within walking distance so the GP was able to easily visit the families of bereaved patients. The lead GP told us they had close links with the mosques in the area and they were frequently contacted following the death of a patient so a death certificate could be issued without delay and a funeral held according to religious beliefs. End of life care was usually carried out by the practice GPs and they told us they had arrangements in place with other GPs in the area if they were going to be on holiday. They would introduce the other GP to families so there was continuity in care. GPs also gave examples of them providing emergency end of life care for patients' relative who had travelled to the UK to be with their family. They told us they would provide immediate and necessary care to these people.

A social worker attended the practice each week and GPs referred patients to see them appropriately. Counselling, including bereavement counselling, was available in the area and referrals were by the GPs or be self-referral. The practice had had a high number of asylum seekers and had noticed an increase in patients with post-traumatic stress disorder. They arranged counselling for these patients and were proactive in making links with counselling services as they anticipated the number of patients requiring this type of help increasing.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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.

- The practice offered late night opening until 8pm once a week.
- There were longer appointments available for all patients as all appointments were allocated according to need.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation. All patients receiving end of life care were seen on the day they requested.
- Text reminders were sent to patients where possible prior to appointments and blood tests.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- During the winter months the practice had a walk-in surgery for a short time in the afternoons. The practice was next door to a large primary school and they had found that during the winter months they had a large number of parents dropping in after collecting their children from school asking for an appointment. Although they still directed patients to the pharmacy if this was appropriate they found the open surgery was the most effective way of managing the needs of the patients and the time of the clinical and reception staff.
- The practice was fully accessible to disabled patients. We saw a patient using a large wheelchair was easily able to manoeuvre their chair into the consulting room. A hearing loop was available.
- Clinicians and reception staff were able to speak several languages. This helped as almost 90% of patients were from black and minority ethnic (BME) backgrounds. Over 30 nationalities were patients at the practice and over 20 languages were regularly spoken by patients.
- Translation services were available, either face to face or on the telephone. The telephone translation service was used several times a day, and was used frequently at the reception desk when booking appointments. The practice was in talks with the CCG about having conference telephones provided to make telephone translation easier. Some languages were not covered by the telephone translation service, and the practice found there was an issue with a dialect of one language. They had developed links with a local community centre were translators were available so when required their volunteers would attend the practice to translate for patients.
- The practice had recognised that some services were not being accessed due to the cultural and religious beliefs of patients. They were focussed on the outcomes for patients and looked at ways to address inequalities.

Access to the service

The practice was open daily between 8am and 6.30pm. On Tuesdays the practice was open until 8pm. Surgeries were throughout the day to offer flexibility for patients. The practice offered on the day urgent appointment, 48 hour appointments where the need was less urgent, and routine appointments that could be booked up to six weeks in advance.

The practice had developed their own appointment system to meet the needs of their diverse patient population. Surgeries were divided into units of activity of five minutes each. This system had evolved after researching and trying different appointment models. Patients were allocated a number of units depending on their need. For example, one five minute unit was usually allocated for a telephone consultation, while a minimum of four units were allocated when an interpreter was required. We saw an example of a patient with post-traumatic stress disorder being allocated 50 minutes. The GP explained that when they were introducing the system they had a period of approximately three months where training was delivered to staff and the model was tested and adapted. Scenario training was held during the practice meetings and there were some weekend meetings arranged while the appointment concept was changing. The staff we spoke with were able to fully explain how they dealt with different requests for appointments, and they said patients were aware they asked for brief information about their need so the appropriate appointment length could be allocated. Staff told us that if they were unsure about how long to allocate to a patient with complex needs they sent an instant message to the GP who would give them guidance. The

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice manager told us that as the majority of patients telephoned the practice in the morning they had more experienced staff on the reception desk and answering telephones during this time. This meant they were more responsive to the needs of the patients. The system was constantly being assessed but patients seemed to be seen when they needed it and although they referred patients to other services such as the pharmacy if appropriate patients were never turned away.

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

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 75%.
- 88% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. On the day of the inspection we saw that emergency appointments were available.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

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

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was an information leaflet available that contained full details of the process, and information could be translated into other languages if needed. The website also contained information and there was the facility to translate this.

We looked at the complaints that had been received. The practice manager told us it was very rare for a patient to complain and they always recorded verbal complaints. We saw that formal written complaints were rare and the practice manager told us a lot of patients struggled writing so they made sure they spoke with them about any concerns they had. We saw that all complaints were investigated and responded to appropriately with patients being told they could refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if they were unhappy with how it had been dealt with. We saw evidence that all complaints were discussed at the weekly practice meeting and staff told us they received guidance on how to learn from complaints.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care that was effective and responsive to the needs of its population and to promote good holistic outcomes for patients.

- The practice had a practice charter which was displayed in the waiting areas. Their mission statement was "Meeting the diverse health needs of the practice population" and staff knew and understood these values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and what they were accountable for.
- A systematic approach was taken to working with other organisaitons to improve care outcomes and tackle health inequalities. This included working with the local mosques and community centres as well as other health and care organisations.
- There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. This was discussed with all staff in the weekly practice meetings. We saw information was kept on al aspects of performance, including complaints, significant events and performance and staff had a good understanding of this.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice was aware the risks to their specific patient population.

Leadership and culture

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

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

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

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

- Staff told us the practice held weekly practice meetings. Clinical staff met separately but the whole team was involved in discussions about the performance of the practice and ways performance could be improved.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at meetings and felt confident and supported in doing so. We saw that they were supported for example when recording significant events and the practice manager recognised when additional support was required.
- The needs and preferences of staff had been taken into account when setting the rotas for the Ramadan fasting

Are services well-led?

Outstanding ☆

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

period. It was recognised that people reacted differently to fasting but by looking at the team as a whole patients could be seen at times convenient to them by staff who were working at the times they preferred.

- Staff said they felt respected, valued and supported by the lead GP and the practice manager. Staff without exception told us how they enjoyed working at the practice. They said they appreciated the practice values and felt communication within the team was particularly strong. Reception staff told us they were made to feel an integral part of the team. All staff were involved in discussions about how to run and develop the practice, and the GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- Reception staff gave us examples of them encouraging holistic care and acting as patients' advocates. For example, one person who was not registered with the practice attended in an anxious state. They did not speak English as their first language. Reception staff were able to find out the issue and identify that the patient needed treatment from another provider. They liaised with this provider and were able to refer the patient to the appropriate service and alleviate their anxieties. Staff told us they were encouraged to help patients in this way and to look for solutions to problems.

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

The practice encouraged and valued feedback from patients, the public and staff. It sought patients' feedback and engaged patients in the delivery of the service.

- The practice manager analysed the results of the NHS friends and family test. We saw the majority of patients were extremely likely to recommend the practice. They also looked at patients' comments to see if changes to their service were required.
- The practice manager told us it was sometimes difficult to gather written feedback from patients due to the diversity of the practice population and the number of languages spoken. Feedback was often verbal.
- The practice had installed an electronic check in facility for patients in response to a patient suggestion. Information was in several different languages so most of the practice population were able to use it.
- The practice had set up a virtual patient participation group (PPG). There was a notice about the PPG in the waiting room and this also provided information in Guajarati. They asked the virtual PPG for comments on the national GP patient survey results.
- At the time of our inspection there was a survey ongoing around the renewal of the practice's contract with the clinical commissioning group (CCG). This was being analysed by the practice and the CCG following the closing date on 3 June 2016.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and looking at ways to holistically manage the different healthcare and social needs of their individual patients. The lead GP had initiated a scheme to set up a city farm very close to the practice. They had recognised that this initiative could improve social isolation, exercise and the perception of safety in the area. They told us that a lot of their families came from farming communities in India and they felt this would encourage them to take part in activities. The scheme was unable to progress due to the council ownership of the identified land, but the GP was looking at other ways to encourage the community to set up this type of scheme as a way of improving their lives and also their health outcomes.

The practice kept real time data relating to the governance of the practice. They had a noticeboard in the administrative office that was updated daily. This gave information such as the number of dictations outstanding, new patients being registered and notes waiting to be summarised. The practice manager explained that this had been brought in approximately two years ago as a measurement of how the practice was working. They felt this was beneficial as it could be identified if staff had particular difficulties or where additional staff could be utilised if needed. They told us this had met with some resistance when it was brought in but now staff saw this as a positive tool to ensure the practice worked well.

Are services well-led?

Outstanding ☆

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

The lead GP had visited a healthcare organisation in Bradford to gain a greater understanding of how they managed their diverse practice population. They told us they tried to keep up to date with new models of care and were constantly looking at ways to improve the health outcomes for their patients.