

Kearsley Medical Centre

Quality Report

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Date of inspection visit: 08/10/2015

Date of publication: 12/11/2015

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Good



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 Kearsley Medical Centre on 8 October 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- Proactive case management for patients within care homes. One GP provides a clinic once a fortnight to work with care and nursing home staff to proactively manage patients care and treatment. This is in addition to regular reactive care provided by the practice. The impact of this work and the proactive involvement of clinicians at the practice resulted in a 37% reduction in unplanned hospital admissions over a 12 month period.

Summary of findings

- The practice had developed a system to improve methods of communicating with vulnerable groups these included; sending letters on coloured paper or easy read letters incorporating pictorial prompts to help patients better understand the content.
- Following changes in GP training nationally, the practice took the opportunity to develop an innovative training post focusing on dementia diagnosis,

assessment, care and treatment working alongside an older people psychiatrist. This post has enabled GP trainees to develop specialist skills in accessing and treating patients with dementia syndrome and raises awareness of dementia within the practice.

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?

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

Good



Are services effective?

The practice is rated as good 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 these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services provided was available at the practice and on the practice website. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

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

Outstanding



The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. For example the joint work within care homes resulting in a 37% reduction in unplanned hospital admissions and the innovative specialist dementia care GP trainee role working alongside older people psychiatrists.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Good



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

The practice is rated as outstanding for the care of older people. The practice supported patients within two large care homes with approximately 1% (130 patients) registered at the practice.

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

The practice had been involved in a number of pilot programmes to improve the outcomes for patients, for example, piloting active case management for patients within care settings. Learning from the pilot informed the working practises of the long term conditions team in Bolton. The practice have maintained in-house case management with one GP providing clinics once a fortnight to work with care and nursing home staff to proactively manage patient care and treatment. This is in addition to regular reactive care provided by the practice. The impact of this work and the proactive involvement of clinicians at the practice resulted in a 37% reduction in unplanned hospital admissions over a 12 month period.

Other examples included a multi-disciplinary approach to medication reviews for patients within care homes. This involved pharmacists, GPs, district nurses and care home staff. Outcomes included, where medication was found to be unnecessary, it was stopped resulting in significant cost savings. Learning from this pilot has informed the commissioning of a multidisciplinary team within Bolton to improve care for all care home patients in Bolton.

Outstanding



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Where appropriate one longer review appointment was made to enable those patients with multiple conditions to have all conditions and medication reviewed at the

Good



Summary of findings

same time, preventing patients having to make repeat visits. For those people with the most complex needs care plans were in place and the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

New parents were sent a congratulations card from the practice which also included information on the six to eight week baby checks. Mothers with babies attend for postnatal check, babies eight week check and first immunisation within a two week period, the practice provided all three appointments at the same time preventing patients having to attend the practice on multiple occasions. A midwife provided weekly clinics from the practice.

Good



Working age people (including those recently retired and students)

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

Appointments were available in advance and from 6:45am to enable those working to have access to GPs or nurses at times convenient to them.

Patients were able to book appointments via "Patient Partner" a 24 hour a day automated telephone booking service and via the practice online services 24 hours a day, 7 days a week.

Telephone appointments were available for patients and patients were able to speak with a GP at 11:00am daily improving access and preventing patients from having to take time off work unnecessarily.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and care plans were produced in easy read format for patients to take away. Where required these were carried out in patients' homes. The practice offered longer appointments for people with a learning disability or those requiring a translator.

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

The practice had developed a system to improve methods of communicating with vulnerable groups these included; sending letters on coloured paper or easy read letter incorporating pictorial prompts to help patients better understand the content. Staff told us that when they follow up patients after written communication or when patients contact the practice, they can identify the type of correspondence from the colour of the letter and the pictures which has helped to improve communication.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 56% of people experiencing poor mental health had a comprehensive care plan in place, agreed between individuals, their families and/or carers as appropriate and in year 43% had received their annual reviews and health checks.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Following changes in GP training nationally, the practice took the opportunity to develop an innovative training post focusing on dementia diagnosis, assessment, care and treatment working

Good



Summary of findings

alongside older people psychiatrists. This posts have enabled GP trainees to develop specialist skills in accessing and treating patients with dementia syndrome and raises awareness of dementia within the practice.

The practice had advised patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was in the main performing above local and national averages. There were 132 responses and a response rate of 36%.

- 83% find it easy to get through to this surgery by phone compared with a CCG average of 79% and a national average of 73%.
- 95% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 63% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85% and a national average of 85%.
- 98% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.

- 87% describe their experience of making an appointment as good compared with a CCG average of 77% and a national average of 73%.
- 57% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 69% and a national average of 65%.
- 59% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received four comment cards which were all positive about the standard of care received and included individual praise for clinical and non clinical staff. The ten patients we spoke with were complimentary of the staff, care and treatment they received.

Kearsley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist advisor, practice manager specialist advisor and expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Kearsley Medical Centre

Kearsley Medical Centre provides primary medical services in Bolton, from Monday to Friday. The practice is open between 06:45am – 6.30pm Monday to Friday.

Appointments with a GP were available between 06:45am – 11:45am and 2:00pm – 5:30pm with the exception of Wednesdays when appointments were until 4:30pm.

Kearsley Medical Centre is situated within the geographical area of Bolton Clinical Commissioning Group (CCG).

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

Kearsley Medical Centre is responsible for providing care to 12908 patients of whom approximately 1% were in residential care homes.

The practice is a training practice, accredited by the North Western Deanery of Postgraduate Medical Education and has two GP specialist trainees, one of whom is in a specialist post focusing on the care and treatment of dementia patients.

The practice consists of seven GPs, two of whom are female, two practice nurses and an assistant practitioner. The practice is supported by a practice manager, deputy practice manager, IT manager, office manager, receptionists and administrators.

When the practice is closed patients were directed to the out of hour's service.

Why we carried out this inspection

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

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

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

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

Detailed findings

- 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)

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 8 October 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with ten patients and ten members of staff, including the GPs, practice manager, practice nurse, assistant practitioner, reception and administration staff.

We reviewed four Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events and clinical events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice computer system. The practice carried out an analysis of the significant events and complaints on an annual basis to identify any patterns or trends.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance, local CCG and NHS England. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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. The lead GP attended local safeguarding meetings on a monthly basis and attended where and when possible case conferences and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room and consulting rooms, advising patients that a chaperone was available, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice carried out a fire risk assessment in July 2014. We noted some risks identified as high had not been addressed for example staff training and fire drills. Speaking with the practice manager they told us a number of the areas had been addressed but the plan had not been updated, outstanding areas would be addressed immediately. All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The practice also 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.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. 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 drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the provider's pharmacist and local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored however there were no systems in place to monitor their use.
- Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Are services safe?

- 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 that enough staff were on duty to meet patient's needs.

Arrangements to deal with 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. All staff received annual basic life support training and there were emergency medicines

available. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment 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 ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet 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 participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 94.6% of the total number of points available, with 16.4% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets and were above local and national average in majority of clinical outcomes. Data from 2014/15 showed;

- Performance for diabetes related indicators was better than the CCG and national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the CCG and national average
- Performance for mental health related indicators was better than the CCG and national average.
- The dementia diagnosis rate was above than the CCG and national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were provided with four examples of clinical audits completed in the last two years, all had completed two cycles where the improvements made were implemented and monitored. Examples include a childhood fever audit, which resulted in a template being developed to aid

clinicians in the management and monitoring of children. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

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

- The practice had an induction programme for newly appointed members of staff including locum GPs that covered policies and procedures and clinical systems alongside topics such as safeguarding, fire safety, health and safety and confidentiality.
- 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 these learning needs and to cover the scope of their work. This included ongoing support from the provider, one-to-one meetings, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Following changes in GP training the practice took the opportunity to develop an innovative training post focusing on dementia diagnosis, assessment, care and treatment working alongside an older people psychiatrist. This posts have enabled GP trainees to develop specialist skills in accessing and treating patients with dementia syndrome and raises awareness of dementia within the practice.
- The newly qualified advanced practitioner was supported to undertake a preceptorship, to support them in the transition phase from being a newly registered practitioner to continue their professional development, building their confidence and further develop competence to practice.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Are services effective?

(for example, treatment is effective)

Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included people moving between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis for patients at risk or unplanned hospital admissions. End of life meetings took place on a monthly basis and as part of the multi-disciplinary meetings care plans were routinely reviewed and updated. We also noted weekly and daily clinical meetings were held in which district nurses, health visitors and integrated nursing team were invited to drop in.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had received training linked to the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, patients with poor mental health and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service such as in house counselling, smoking cessation or local health trainers who held appointments at the practice twice a week. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice uptake for the cervical screening programme was 77% which was in line with the CCG and the national average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, NHS England figures showed in 2015, 95% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Flu vaccination rates for the over 65s were 74% and at risk groups 49%. These were in line with to CCG and national averages.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that 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 four patient CQC comment cards we received and the ten patients we spoke with 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. Comments included good continuity of care, staff responded compassionately when patients needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice had higher satisfaction scores on consultations with doctors and nurses to national and CCG scores. For example:

- 99% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 96% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 95% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

- 95% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed 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% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

The practice used care plans to understand and meet the emotional, social and physical needs of patients, including those at high risk of hospital admission and poor mental health. Data showed the practice had personalised care plans in place for patients at risk of unplanned hospital admissions and we noted reviews of the care plans had taken place. Additionally the practice also had care plans in place for patients over 75, patients with chronic diseases and dementia.

The practice population included 1% of patients living in nursing or residential care homes. One GP held fortnightly clinics for care homes to review care plans, medication and engage patients and their relatives, where appropriate regarding end of life care.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room advised patients how to access a number of support groups and organisations.

The practice computer system alerted GPs if a patient was also a carer. There was a practice register of all people who

were carers. Written information was available for carers to ensure they understood the various avenues of support available to them and a dedicated display board was kept up to date in the waiting area.

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



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, attending locality meetings and working with other health and social care professionals, this included piloting and reviewing new ways of working such as meeting the needs of patients within a care home.

Services were planned and delivered to take into account the needs of different patient groups and to help provide and ensure flexibility, choice and continuity of care. For example;

- The practice offered GP appointments from 06:45am Monday to Friday.
- There were longer appointments available for people with a learning disability or who required a translator.
- Combined appointments up to 30 minutes were provided for reviewing patients with multiple long term conditions to prevent patients having to make several appointments/visits to see a nurse or GP.
- Home visits were available for older patients and patients who would benefit from these.
- The practice commissioned a daily phlebotomy service to enable patients to have in house blood tests carried out.
- The practice were able to initiate insulin within the practice type 2 diabetes patients where required, enabling patients to receive the care and treatment within the practice rather than being referred to secondary care services.
- The practice offer in house Palpitation clinic in which patient are provided with a palpitation watch which monitors the heartbeat allowing GP to get accurate data to provide care and treatment or referrals to specialist services.
- Urgent access appointments were available on the day for all patients including children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- Following input from a member of the Patient participation group the practice had made alterations to

improve facilities for patients with disabilities, for example for those with visual impairment they had changed signage on doors and painted corridor in different colours.

Access to the service

The practice was open between 06:45am – 6.30pm Monday to Friday. Appointments with a GP were available between 06:45am – 11:45am and 2:00pm – 5:30pm with the exception of Wednesdays when appointments were until 4:30pm. In addition to pre-bookable appointments that could be booked from 2 days and up to four weeks in advance, urgent appointments were also available on the day for people that needed them.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 87% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 83% patients said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%.
- 87% patients described their experience of making an appointment as good compared to the CCG average of 77% and national average of 73%.
- 57% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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 Patients we spoke with were aware of the process to follow if they wished to make a complaint.



Are services responsive to people's needs? (for example, to feedback?)

The practice kept a complaints log for written and verbal complaints. We looked at four complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the compliant.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. The practice carried out an annual review of complaints to identify any patterns or trends and these were shared during team meetings.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice mission statement was clearly displayed for staff and patients at reception.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs, with one GP a member of the CCG standards board.

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 responsibilities.
- The practice employed a pharmacist to audit medication and prescribing within the practice and look at opportunities to make efficiencies.
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice was in place with non clinical audits in place.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners and managers within the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The management team were visible, the practice manager had an open door policy and

alongside the GP partners they were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The practice encouraged a culture of openness and honesty.

The practice had clinicians within the practice with a range of clinical expertise, including cardiology and diabetes. Speaking with staff they valued learning from and seeking support from colleagues with areas of expertise enabling them to provide quality care for patients.

Staff told us that regular clinical team meetings were held, including daily meeting of clinicians in which external professionals were also invited to drop in, to enhance multi-disciplinary working. Weekly formal clinical meeting were held and minuted and as were practice partner meetings.

Staff meetings were held weekly until April 2015 when the practice increased their opening hours. Staff noted the loss of these meeting as a means of communication, despite the introduction of alternative means of communication such as emails and mini informal meetings. The practice manager was aware of concerns and was working with staff to look at different means of meeting and communicating with staff.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the lead GP and practice manager in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was a small group of PPG members; however the chair had recently resigned. The practice was taking the opportunity to re look at patient participation and was looking to launch a virtual group to increase involvement. The practice had also gathered

Are services well-led?

Good 

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

feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and was involved in a number of local pilot schemes to improve outcomes for patients in the area. Examples included: Piloting active case management in the practice. Learning from the pilot informed the working practices of the Long term Conditions Team in Bolton and the practice have maintained in-house case management with one GP

providing clinics once a fortnight to work with care and nursing staff at a large care home to proactively manage patients and reduce unnecessary medication. This is in addition to regular reactive care provided by the practice. The impact of this work and the proactive involvement of clinicians at the practice resulted in a 37% reduction in unplanned hospital admissions over a 12 month period.

Other examples included a multi-disciplinary approach to medication reviews for patients within care homes. This involved pharmacists, GPs, district nurses and care home staff. Outcomes included medication being reviewed and where it was found to be unnecessary it was stopped and significant cost savings were made. Learning from this pilot has informed the commissioning and working practices for a multidisciplinary team commissioned to improve care for all care home patients in Bolton.