Bolton General Practice

Quality Report

Marsden House,
Marsden Road,
Bolton,
BL1 2AY
Tel: 01204 521000
Website: www.ssphealth.com

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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?	Good ●
Are services caring?	Outstanding ☆
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 Bolton General Practice on 16 June 2017. 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, working with other local providers to share best practice. For example employing a patient liaison officer, a weekly 'Conversation café' and patients could access free gym facilities at a neighbouring SSP practice.
- 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.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- 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.
- The practice had a diverse population and in order to meet the needs of patients from a different background and those for whom English was not their first language, the practice had multi-lingual literature, attended local community events and worked with local organisations such as the Befriending Refuges and Asylum Seekers (BRASS).

We saw several areas of outstanding practice including:

Summary of findings

- The practice were proactive in providing safety nets for vulnerable and at risk patients. For example, the practice initiated a 'do not allow to DNA' register. This was created to ensure that vulnerable patients who required follow up, referrals or treatments following consultations were proactively contacted to ensure they attended their appointment. The practice also monitored vulnerable patients on high risk medication who were assessed as being at risk of not complying with their medication. The practice put in place multiple safety nets for these patients.
- The practice recognised the need for advocacy and support services for patients to be provided in house and had a number of initiatives on-going, for example, the practice employed a patient liaison officer to provide advocacy for vulnerable patients especially those for whom English was not their first language and those new to the practice. They acted as a focal point for communication between patients, GPs and other health and social care teams. The practice had also become increasing aware of the impact on patients physical and emotional wellbeing in light of changes to the benefit system and patients being refused asylum. As a result the practice supported patients with legitimate reasons to appeal against these decisions by providing detailed medical letters and reports when required.
- The practice recognised that social isolation was a key issue for some patients and the practice had established a number of services to address this, for example, patients living in social isolation or new to the practice were invited to attend a weekly conversation café. The conversation café was run by the patient liaison worker, attended by staff, voluntary organisations and community workers. Patients could drop in for advice, guidance and support or to meet new people. The practice had also introduced welfare appointments with the health care assistant. These could be accessed by filling in a confidential 'loneliness slip' or speaking with a member of staff.

However there was one area of practice where the provider should make improvements:

- Ensure all sharps bins are signed and dated.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that there were systems to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that 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 were above the CCG and national average at 99%. (11% above the CCG average and 9% above the national average).
- The practice created an 'important patient' register to ensure the needs of the most vulnerable patients were being met and their care was best monitored.
- The practice used innovative and proactive methods to improve patient outcomes working with other local providers to share best practice, these included initiating a do not allow to

Summary of findings

DNA system to ensure patients attended for treatment where required and working closely with a number of local organisations such as Befriending refugees and asylum seekers (BRASS) and Urban outreach.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care in innovative and efficient ways.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We observed a strong patient-centred culture
- Data from the national GP patient survey showed patients rated the practice in line with others for several aspects of care.
- Survey information we reviewed showed that 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 available was accessible and translated into multiple languages or in large print.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- We spoke with 13 patients who gave examples of how the practice had made a difference to their wellbeing and where staff had gone above and beyond.
- Views of external stakeholders were very positive.
- The practice had a patient liaison officer to provide advocacy for vulnerable patients especially for those for whom English was not their first language and those new to the practice. They acted as a focal point of communication between patients, GPs and other members of the primary health care team.
- The practice recognised that social isolation was a key issue for some patients. In the past 12 months the practice introduced a confidential system in which patients could request a welfare appointment with the Health Care Assistant if they felt lonely or isolated.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.

Summary of findings

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- There were innovative approaches to providing integrated patient-centred care. For example the practice held a weekly conversation café in which patients could meet socially and access support and guidance.
- Patients could access appointments and services in a way and at a time that suited them. This included a GP being on site throughout opening times.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients who required additional support and their care monitored were included on an 'important patient' register which was monitored on a daily basis and care needs followed up where required.
- The practice had patient champions in place. Staff taking on these roles were clearly identified and provided signposting and checked in with patients where appropriate to follow up appointments and check on their welfare.
- Patient's feedback suggested they found it easy to make an appointment with a named GP and there was continuity of care. Urgent appointments were available the same day.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.

Summary of findings

- The GPs, managers and directors all encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. All patients aged over 75 years were offered health checks and care plans.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified, at an early stage, older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services and signposted to relevant social care and voluntary organisations for additional support.
- The practice had a dedicated Carers' Champion whose role included maintaining the register of carers and signposting to other services. In addition the practice also had champions for palliative care and cancer patients.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Outstanding ☆

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice offered appointments up to 45 minutes for those with multiple long term conditions, offering a holistic review.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

Summary of findings

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- For patients with long term and multiple long term conditions the practice was proactive in preventing their condition from worsening.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicine needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- Congratulation letters were sent to parents of new babies and new parents were provided with an early year's fact sheet, developed by SSP, providing information around vaccination schedules, breast feeding, cervical screening and other health related information.
- Breast feeding facilities were available.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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).

Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended hours included appointments 9am to 12:30pm on Saturdays. The practice also participated in a local extended hours hub where patients could access GP services in the evening and on Saturdays and Sundays.
- 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.
- Telephone consultations were available daily.
- The practice hosted ultrasound clinics on site from other health providers. This enabled patients to access services closer to home preventing them having to travel to access care and treatment.
- The practice had condoms readily available for patients to pick up as and when required.

People whose circumstances may make them vulnerable

Outstanding ☆

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

- The practice population experience higher levels of income deprivation affecting children and older people than the practice average across England. The practice supported homeless patients and provided shared care for patients with alcohol/substance misuse problems. The practice also had 1480 refugees and asylum seekers registered and approximately 48% of patients were non-English speaking.
- The practice held a register of patients living in vulnerable circumstances known as the 'important patient register' including homeless people, vulnerable adults and those with a learning disability. This ensured the needs of the most vulnerable patients were being met and their care and welfare was monitored.
- The practice has a patient liaison officer to provide advocacy for patients in this population group and acted as a focal point of communication between patients, GPs and other members of the primary health care team.
- The lead GP worked in partnership with the local drug and alcohol team and complex lifestyle team to provide co-ordinated care for patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Summary of findings

- The practice offered longer appointments for vulnerable patients including those with a learning disability.
- The practice used telephone translation services and routinely offered extended appointments (30 to 45 minutes) to those requiring a translator. The practice also had for example a Welcome pack which explained in various languages about the practice and covered subjects such as the prescribing of antibiotics, cervical screening, childhood immunisations, COPD and Heart Failure.
- The practice recognised isolation was an issue for many vulnerable patients and provided welfare support to those feeling lonely and isolated and also invited people to a weekly drop in conversation café at the practice.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- The practice carried out advanced care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 93% of patients with poor mental health had a comprehensive care plan documented in the record agreed between individuals, their family and/or carers as appropriate.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.

Summary of findings

- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations. Staff signposted patients to the self-referral counselling services Think Positive who provide help for people with anxiety and depression.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed 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 national GP patient survey results were published on 7 July 2016.The results were the same as or lower than local and national averages. 355 survey forms were distributed and 85 were returned. This represented approximately 2% of the practice's patient list.

- 78% of patients described the overall experience of this GP practice as good compared with the CCG average of 87% and the national average of 85%.
- 72% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 69% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to 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 68 comment cards which were all positive about the standard of care received. Comments included: experience is very very good and I love coming here, felt listened to, reception staff were very helpful, everything is excellent and an amazing doctor and can get an appointment on a Saturday.

We spoke with 13 patients including two member of the patient participation group during the inspection. All the patients said they were happy with the care they received and thought staff were approachable, committed and caring. Comments included: Helped improve English speaking skills, benefit from attending the conversation café, the manager is very good and approachable, 10 out of 10, very happy, they don't just dish out medication they help, staff are very patient, they have supported whole families though bereavement and they will go the extra mile.

The practice had conducted an in house patient's survey during April 2017, which was completed by 314 patients (6% of the patient list). Analysis of the survey by the practice showed when asked:

- Are you happy with the overall Patient Experience when you visit our practice? 87% said yes.
- Would you recommend this practice to your family and friends? 95% said yes.
- When you last visited the surgery, were you treated with dignity and respect by:
  - GPs 94% said yes
  - Nurses 98% said yes
  - Administration staff 94% said yes

Information from the "Friends and Family Test" indicated that the vast majority of patients completing the form were extremely likely or likely to recommend the practice to others. For example, results for March 2017 showed that out of 135 patients, 43% were extremely likely and 50% likely to recommend the practice.

Bolton General Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a GP specialist adviser and an Expert by Experience.

Background to Bolton General Practice

The Bolton General Practice provides primary medical services in Bolton from Monday to Saturday. The surgery is open Monday to Saturday:

Monday, Tuesday, Thursday and Friday 8am to 6:30pm, Wednesday 7am to 6:30pm and Saturday 9am to 12:30pm.

Appointments with a GP are available throughout the opening times Monday to Saturday. A GP is onsite at all times and available to see patients urgently if required. This was in acknowledgement of the number of vulnerable patients registered at the practice who may not be in a position to keep to appointment times. Additionally patients can access GP services in the evening and on Saturdays and Sundays through a local extended hours hub.

Bolton General Practice is situated within the geographical area of Bolton Clinical Commissioning Group (CCG).

The practice has an Alternative Provider Medical Services (APMS) contract. The APMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. It offers direct enhanced services for meningitis provision, the childhood vaccination and immunisation programme, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, rotavirus and shingles immunisation and unplanned admissions.

Bolton General Practice is responsible for providing care to 5255 patients. The population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There is a higher proportion of patients aged 5 to 44 (74%) compared to a national average of 52% and a lower average of patients over 65, 2% compared with 17% nationally. There are a high number of patients registered who are from Black and minority ethnic groups (BME), this being 76% compared to 16% nationally. The practice also has 1480 refugees and asylum seekers registered with the practice and approximately 48% patients are non-English speaking.

The practice consists of three GPs, one full time lead GP (male) and two part time GPs (one male and one female). The practice also has bank and locum GPs, a full time practice nurse and a health care assistant. The practice is supported by a practice manager, assistant practice manager, receptionists and administrators.

The practice is part of SSP Health Primary Care Limited, a federated organisation which benefits from support from the leadership and governance teams. The practice has access to support and leadership from, for example a nursing lead and pharmacist as well as access to human resources, auditing and finance teams. When the practice is closed patients are directed to the out of hours service.

Detailed findings

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 16 June 2017. During our visit we:

- Spoke with a range of staff including the lead GP, practice manager, nurse, patient liaison worker and receptionists, as well as staff from SSP Health Primary Care Limited including a director and the chief operating officer. We also spoke with members of the patient participation group and a worker from the Complex lifestyles team.
- Observed how patients were being cared for in the reception area and talked with patients, including those attending the conversation café.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. 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).
- From the sample of 32 documented significant events we reviewed four in detail and found these were appropriately investigated and actions and outcomes shared. We saw that where appropriate, when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events. The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding 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 member of staff and deputy for safeguarding. The practice were also able to seek advice and guidance from the SSP safeguarding lead.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- Staff within the practice had received training in relation to domestic violence and are an accredited referral centre and work collaboratively with staff from (Identification and Referral to Improve Safety) IRIS to support patients.
- Staff at the practice were proactive in supporting patients at risk and/or who had been subject to Female Genital Mutilation (FGM). The practice held a patient register which also included children who may be at risk to monitor their welfare and offer support where required.
- A notice in the waiting room and consultation rooms advised patients (including translated notices) 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).
- The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were reviewed at practice meetings by the GPs, practice nurse and practice manager and audits were carried out where required. Action taken as a result was recorded.
- The practice maintained appropriate standards of cleanliness and hygiene.
- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The health care assistant was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC 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 minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). We noted however that sharps bins had not been signed and dated. Speaking with the practice they

told us they had consulted with the waste management company who advised them this was not required. They told us they would address this immediately following the inspection.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being given to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits. There was a pharmacist from SSP who worked with the practice to support regular medicines audits and to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files including those for locum GPs and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were 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 stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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 98.8% of the total number of points available, 4% above the clinical commissioning group (CCG) average 3.5% above the national average. Overall exception rate for the practice was 8.2% (0.8% above the CCG average and 1.6% above the national average) (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators were above the CCG and national average at 99%. (11% above the CCG average and 9% above the national average).
- The percentage of patients with hypertension having regular blood pressure tests was comparable to the CCG and national average at 100% (1% above the CCG average and 3% above the national average.)
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were above the CCG and national average at 100% (4% above the CCG and national average.)

In order to meet the needs and improve the outcomes of patients the practice implemented a number of initiatives for example:

- The practice monitored the most vulnerable patients through an 'important patient' register to ensure their needs were being met and their care was monitored. This included for example approximately 30 homeless patients, patients with multiple long term conditions, mental health, learning disabilities, safeguarding including those at risk of female genital mutilation. The register was overseen on a daily basis by the assistant practice manager and lead GP to ensure patients' needs were being met and reviewed on a regular basis.
- For patients with long term and multiple long term conditions the practice were proactive in preventing their condition from worsening for example, for patients with recurrent chest infections the GP arranged for them to provide a sputum sample as early as possible if they thought they were having an exacerbation. The end result was quicker and more appropriate antibiotic prescribing and better outcomes for patients.

There was evidence of quality improvement including clinical audit:

- There had been a range of full cycle and single cycle clinical and non-clinical audits completed in the last two years. We saw five examples of full clinical audits and nine audits carried out in response to MHRA alerts. Audits had been identified from clinical events, CCG data and review of new clinical guidance. We were provided with examples of completed audits where the improvements made were implemented and monitored, these included audits linked to MHRA alerts, referrals, new cancer diagnosis to ensure best practice guidance was followed and to enable early detection where possible and anticoagulant monitoring.
- The practice also carried out non clinical audits which looked at for example, patient access.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. The practice worked with key performance indicators set by the local CCG and met with the CCG and other local GPs to benchmark, monitor and review quality. The practice used data to effectively monitor and improve outcomes for patients.

Good

Are services effective?

(for example, treatment is effective)

- A pharmacist provided support to the practice. They ran prescribing safety checks and audits, where any issues were highlighted these were passed to a GP to act on. The practice also received support from the CCG medicines management team.
- Outcomes of audits were discussed routinely during clinical meetings within the practice.
- The practice worked with key performance indicators set by the provider SSP and met with colleagues within the organisation to monitor and review quality on a monthly basis.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge 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.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- 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 could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, nurse and clinical leads with SSP 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 and nurses. All staff had received an appraisal within the last 12 months.
- 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.

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.
- 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. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.
- Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals regularly when care plans were routinely reviewed and updated for patients with complex needs. The practice met routinely with the Integrated care team to ensure care was coordinated within the community.
- The practice worked closely with a range of local organisations to coordinate care and support for patients, these included the charity Befriending Refuges and Asylum Seekers (BRASS). The lead GP also worked closely to provide shared care with the Complex lifestyles team and Bolton Integrated Drug and Alcohol Services (BiDAS). We noted 91 (approximately 2%) of patients registered with the practice had issues with alcohol/substance misuse with 85% requiring a medical intervention. The practice had also made 22 referrals to the complex lifestyles team in the past three months. One worker from the Complex lifestyle team told us the care and treatment provided by the lead GP at Bolton General Practice was unique and person centred, where the GP attended meetings and was proactive in care planning for patients.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

Good

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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Staff would use an official telephone translation service to ensure non English speaking patients understood and consented to care and treatment. Patients who required a translator were routinely provided with double (30 minute) appointments.
- 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.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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 worked with a number of local health and social care providers in the area including Urban Outreach, BRASS, local food banks, and Carer's Resource and Butterflies a local support group for families who had lost a child. We saw examples where the practice had played a key role in promoting improved outcomes for patients by working closely with community groups.
- Patients from Bolton General Practice had free access to a gymnasium at a neighbouring SSP practice (Bolton Medical Centre) set up and run by the provider SSP Health Primary Care Limited. The gym was open Monday to Saturday including an evening session and female only sessions. Membership was offered to registered patients as a means to help improve their health and well-being in particular weight loss but also social isolation. Once registered with the Gym patients participated in an induction which included details of current health problems, core information such as Body Mass Index (BMI) and goals which were then reviewed every three months to monitor outcomes. We saw evidence that on average 39 patients used the gym on a daily basis. From the most recent evaluation in April 2017, 14% of patients attending the Gym were registered at Bolton General Practice.
- The practice had a diverse population and in order to meet the needs of patients from different background and those for whom English was not their first language, the practice had multi-lingual literature including a welcome pack, they attended local community events and worked with local projects such as BRASS. The practice also had dedicated information and notice boards in the waiting areas with information translated into key languages.

The practice's uptake for the cervical screening programme was 85%, which was above the CCG and the national average of 81%. We noted however exception reporting was higher than average at 15%, which was 8% above the national average. Speaking with the practice staff this was thought to be due in part to the high number of BME patients and cultural barriers. The practice had engaged with the CCG and other local services to educate patients and encourage the uptake of recommended screening programmes. The practice had a number of initiatives to improve uptake including translated literature and staff spending time with patients to understand the benefits of screening.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable with CCG and national averages. For example, NHS England figures showed that in 2015/16 97% of children aged 5 years had received the full measles, mumps and rubella (MMR) vaccination which was above to the national average of 88%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. 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 also encouraged its patients to attend national screening programmes for bowel and breast cancer.

There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. This included translating

Good

Are services effective?

(for example, treatment is effective)

screening letters, hand delivering information including two week wait referrals to vulnerable patients to ensure they understood what the screening/referrals were for and the importance of attending appointments.

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect. We saw a strong patient-centred culture:

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.
- Speaking with staff who had taken on the role of champion, we noted they were passionate and committed to ensuring patient had access to information and signposting to relevant organisations.
- We were provided with several examples of staff understanding patient's individual needs and providing support where necessary.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.
- The practice had a food bank and clothes bank in the reception and patients could help themselves to items they may require. The practice also referred patients to the local food bank and signposted to where they could get emergency food parcels.
- The practice employed a patient liaison officer who had the care of patients as a key task. Their role was to provide advocacy for vulnerable patients especially those for whom English was not their first language and those new to the practice. They acted as a focal point for communication between patients, GPs and other members of the primary health care team. They also proactively signposted to other local services such as BRASS. The patient's liaison officer would also arrange to meet patients at the practice and accompany them to introduce them to other local services such as The Destitution Project which provides food, clothes and household goods for refused asylum seekers who were awaiting an appeal or who simply could not return to their country of origin. Speaking with the liaison worker we found they were passionate about the role and enabling people to access services and improve their wellbeing. On average they worked with 10 new patients weekly which reflected the transient nature of the patient population.
- The practice recognised that social isolation was a key issue for some patients. In the past 12 months the practice introduced a confidential system in which patients could request a welfare appointment with the Health Care Assistant. Requests could be made in person or by filling in a confidential 'loneliness slips'. Early analysis of the service by the practice showed 33 patients requested one-to-one 'chats' (a 30 minute consultation) following self referrals using the 'loneliness slips'. Initial consultations were then followed up monthly to monitor patients wellbeing where required. This included two weekly telephone calls to check in with individuals, attendance at the conversation café to meet other people and/or a same day appointment with a GP.

All of the 68 patient Care Quality Commission comment cards we received were positive about the service experienced. Comments included: good friendly receptionists and practice nurse, ladies on reception are always happy, polite and very informative, they go above and beyond and the patient liaison worker is very helpful and explains everything.

We spoke with 13 patients including one member of the patient participation group during the inspection. All the patients said they were happy with the care they received

and thought staff were approachable, committed and caring. Comments included: always a smile when you come in, Doctors takes time to listen to people especially in time of need and can see a female GP when needed.

The practice had conducted an in house patient's survey during April 2017, which was completed by 314 patients (6% of the patient list). Analysis of the survey by the practice showed when asked:

- Are you happy with the overall Patient Experience when you visit our practice? 87% said yes.
- Would you recommend this practice to your family and friends? 95% said yes.
- When you last visited the surgery, were you treated with dignity and respect by:
  - GPs 94% said yes
  - Nurses 98% said yes

Are services caring?

- Administration staff 94% said yes

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice results were comparable with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average and national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG and national average of 87%.
- 84% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 91% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 91% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 87% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared with the CCG average of 89% 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.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responses were positive with regard to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 90%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients requiring an interpreter were provided with double (30 minute) appointments and in some case triple appointments to ensure they fully understood the care and treatment proposed. The practice also had a range of patient information translated into key languages to give to patients. The practice also had dedicated notice boards in the waiting areas with information translated.
- The 'Choose and book' service was used with patients as appropriate. (Choose and book is an electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. If required for the most vulnerable the patient liaison worker would assist in helping patients understand the referral and need to attend appointments and in some cases staff would hand deliver information about appointments to patients at home.
- The practice monitored and peer reviewed referrals made by clinicians to ensure they were appropriate and carried out in appropriate time frames.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices (including translated information) were available in the patient waiting area which told patients how to access a number of

Are services caring?

support groups and organisations. Support for isolated, house-bound and vulnerable patients was monitored and these patients were included within the practice 'important patient' register.

The practice worked closely with the complex lifestyle team, mental health teams, Urban outreach and Befriending Refuges and Asylum Seekers (BRASS) in supporting patients with additional social and emotional needs.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 101 patients as carers including young people (approximately 2% of the practice list).

There was a Carers Champion within the practice and a dedicated carer's information board within the waiting area. Carers were provided with an annual health review and where it was difficult for carers to attend the practice for appointments due to caring responsibilities home visits were available. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement the bereavement champion would contact them or send them a sympathy card. This would either be 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. The practice also referred patients to Butterflies a local support group for families who had lost a child. We spoke with three patients who told us, in their view the excellent care and treatment they and their families had received following a bereavement and the care and compassion shown by all the staff at Bolton General practice and described how staff often went above and beyond.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- Bolton General Practice is responsible for providing care to 5255 patients. The population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There was a higher proportion of patients aged 5 to 44 (74%) compared to a national average of 52% and a lower average of patients over 65, 2% compared with 17% nationally. There was a high number of patients registered who were from Black and minority ethnic groups, this being 76% compared to 16% the national average. The practice also had 1480 refugees and asylum seekers registered and approximately 48% of patients were non-English speaking. As a result they provided a proactive approach to understanding the needs of the diverse population and promoted equality by providing a range of services and innovative approaches to provide responsive and integrated patient-centred care.
- People's individual needs and preferences were central in meeting patients' needs and the services provided were flexible and tailored to provide people with choice. The practice involved other professionals, organisations, patients and their families to meet individual's social, emotional and physical needs. We saw a range of examples and innovative approaches to providing integrated person-centred care particularly for patients with multiple and complex medical and social needs. For example:
- The practice has become increasingly aware of the impact on patients physical and emotional wellbeing in light of changes to the benefit system and patients being refused asylum. The practice told us patients who were historically in receipt of benefits for legitimate medical problems and disabilities following reviews had their benefits withdrawn. As a result the practice had supported patients with legitimate reasons to appeal these decisions by providing detailed medical letters and reports. Data from the practice showed that in a two week period in June 2017 they had supported 16 patents in appealing against decisions. Case studies provided by the practice showed positive outcomes in relation to patient's wellbeing and gratitude from patients to the support received by the practice.
- The practice also supported patients with their asylum applications and appeals where asylum had been refused. This work is led by the lead GP who told us 'patients often require the support of the practice to assist them with their application to the Home Office. The threat of deportation back to a place of perceived danger has a huge impact on emotional wellbeing'. We were provided with 15 examples from a three month period (March to June 2017) where supporting letters from Bolton General Practice and/or clinical correspondence were crucial in winning asylum appeals. This included a patient who had been subject to FGM and the potential risk to their children and several patients with poor mental health.
- Patients living in social isolation or new to the practice were invited to attend a weekly conversation café set up and run by the practice since 2012. The conversation café was run by the patient liaison worker where patients could meet socially. The conversation café was attended by staff, voluntary organisations and community workers. Patients could drop in for advice, guidance and support or to meet new people. In addition the welfare chat service with the HCA was promoted to patients who felt lonely or isolated for more focused support. On average 15-20 people attended on a weekly basis. Feedback was continually positive and case studies provided by the practice showed patients went on to engage in the community and take up education and volunteering opportunities.
- The practice promoted the role of champions in which staff took a key role in supporting specific patients groups for example, the practice had a dedicated carers champion who maintained regular contact with carers, offered advice and support and liaised with local services to ensure information within the practice was relevant and up to date. The practice also had a cancer champion in place, whose role was to proactively contact newly diagnosed patients or those under investigation to offer support and be a point of contact should patients have any queries. We saw that staff regularly visited patients who may have been called for a two week wait appointment to ensure they attend and

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

understand their appointment using a telephone translation service where required. We were provided with several examples of the positive impact champions had in relation to patient outcomes.

- Where it was relevant this process also ensured patient care was co-ordinated with the integrated Neighbourhood team and complex lifestyle team. We were provided with examples of how proactive monitoring of vulnerable patients had positive outcomes including, supporting a vulnerable adult with dementia to remain in their own home by working closely with social services and elderly mental health workers. Other examples included supporting patients with alcohol dependency by providing a dedicated member of staff to be a link between patient and GP resulting in patients becoming abstinent.
- The practice initiated a 'do not allow to DNA' register. This was created to ensure that vulnerable patients who required follow up, referrals or treatment following consultations were proactively contacted to ensure they attended their appointment. Where the practice exhausted all their contacts they would contact the police where appropriate to carry out welfare checks making every effort to get the care and treatment patients required. We were provided with examples of positive outcomes including a patient who did not attend for breast screening; the patient was subsequently received treatment at an early stage.
- The practice actively monitored vulnerable patients on high risk medication who were at risk of not complying with their medication. The practice put in place multiple safety nets for patients and often one to one care from the lead GP including regular telephone calls, fast track appointments and a dedicated link workers to track and monitor patients to ensure wherever possible they comply with prescribed medication.
- The practice was open Monday to Saturday and appointments with a GP were available throughout the opening times. A GP was onsite at all times and available to see patients urgently if required. This was in acknowledgement to the number of vulnerable patients registered at the practice who may not be in a position to keep to appointment times. On average the practice provided 5-7 additional ad hoc GP appointments daily.
- All appointments were 15 minutes as standard. In addition to these complex patients including those with learning disabilities or poor mental health or those who required a translator were able to access double appointments (30 minutes) and in some circumstances triple appointments. We saw from data provided by the practice on average 25% of daily appointments with GPs and nurses were double appointments. Same day appointments and or telephone consultations were available for children.
- The practice allocated 70% of appointment as bookable on the day in response to the transient and complex patient population for whom many could not always keep to a schedule of advance pre booked appointments. The practice did however keep the majority of appointments on a Saturday as pre bookable to accommodate those patients who worked. Patients also benefited from the practice being part of a wider SSP organisations for example in the event a convenient or urgent appointment was not available, an alternative appointment could be made with a neighbouring SSP practice. The practice sent text message reminders of appointments.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop and information was available in large print.
- The practice had achieved Gold in the NHS 'Pride in Practice' award from the Lesbian, Gay and Transgender foundation. The practice has also appointed a member of staff who is the champion for LGBT patients.

Access to the service

The surgery is open Monday to Saturday:

Monday, Tuesday, Thursday and Friday 8am to 6:30pm, Wednesday 7am to 6:30pm and Saturday 9am to 12:30pm.

Appointments with a GP were available throughout the opening times Monday to Saturday. A GP was onsite at all

times and available to see patients urgently if required. Appointments could be pre booked up to six weeks in advance or on the day. Additionally patients could access GP services in the evening and on Saturdays and Sundays through a local extended hours hub.

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

- 76% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 76%.
- 62% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 83% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 88% of patients said their last appointment was convenient compared with the CCG and national average of 92%.
- 72% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 39% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

The practice had a system to assess:

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

This was achieved by the GP triage, in which a GP would telephone the patient or carer in advance to gather information to allow an informed decision to be made on prioritisation according to clinical need. 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. The practice also responded to walk in patients; their needs were assessed by a GP if they were willing to wait.

Listening and learning from concerns and complaints

The practice had a system 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.

We looked at two complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way with openness and transparency. Compliments and complaints were also discussed routinely within practice meetings. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. An annual analysis of all compliments and complaints was carried out to identify any patterns or trends.

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. This aligned with the overarching values of the provider SSP Health Primary Care Limited (SSP).
- The practice had a clear 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 and ensured that:

- The practice was part of SSP Health Primary Care Limited, a federated organisation and benefited from support from the leadership and governance teams. The practice had access to support and leadership from, for example a nursing lead and pharmacist as well as access to human resources, auditing and finance teams. In addition staff and patients within the practice benefitted from being part of a wider federated organisation through shared learning, training, mentoring and personal development. Staff told us this helped to improve safe care and treatment as they always had colleagues to call upon and were able to seek advice where required.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All clinical and non clinical staff had lead roles in key areas such as chronic disease management and patient champion roles.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. The practice manager also attended meetings with SSP to review the practice performance.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. This was supported by a dedicated audit team within SSP
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a comprehensive structure in place led by SSP to enable learning and share best practice, this included peer review and collaborative working.
- We saw evidence from minutes of meetings that there was a structure that allowed for lessons to be learned and shared following significant events and complaints.
- The practice manager regularly attended meetings with the provider and fedback to the team any relevant developments within the organisation as a whole.

Leadership and culture

On the day of the inspection the lead GP, practice manager and leadership team from SSP 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 managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems 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 organisation encouraged a culture of openness and honesty. 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 and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses, integrated neighbourhood team and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.

Are services well-led?

Good

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the mangers and lead GP in the practice. All staff were involved in discussions about how to run and develop the practice, and the practice encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had an in house reward scheme, practice employee of the month in recognition of an individual's ongoing contributions. We noted these were prominently displayed within the practice. This was in addition to the reward scheme offered by SSP to all staff across the organisation.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received.
- The PPG met on monthly basis with a core group of eight members attending. Two members of the PPG told us that the group was diverse with people from different cultures, physically able and disabled included. They felt if they had any feedback for the practice, they would make a note of any concerns, pass them to the practice and by the next meeting things had been resolved.
- The NHS Friends and Family test, complaints and compliments received and via the suggestion box.
- Staff through an annual staff survey carried out by the provider, 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.
- The practice carried out in their own internal patient satisfaction survey and the results and actions plans were discussed with staff. We noted from the survey carried out in April 2017 patients were encouraged to give feedback on areas for improvement and an action plan developed.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the staff recognised the need to provide support and advocacy for patients especially refugees and asylum seekers to settle into the community. The practice also continued to develop the role of patient champions within the practice to support the ever changing needs of the patient population.