Hollinwood Medical Practice

Quality Report

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Oldham
Lancashire
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Website: www.hollinwoodpractice.org.uk

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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?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as outstanding. (Previous inspection March 2015 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those recently retired and students – Outstanding

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Hollinwood Medical Practice on 20 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear embedded systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice was open and transparent and valued the lessons learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. There was a holistic approach to assessing, planning and delivering care which included understanding the importance of social and emotional needs in promoting well-being. It ensured that care and treatment was delivered according to evidence- based guidelines and was proactive in working collaboratively with others and devising innovative approaches to improving patient outcomes.
- Staff were highly motivated to provide person-centred care and treatment and enable patients to be actively involved in managing their own care and treatment. Staff treated patients with compassion, kindness, dignity and respect and always took patients personal, cultural, social and religious needs into account.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. The practice had been proactive in amending the appointment system in response to patient feedback.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels of the organisation. The organisation inspired staff to be innovative in their approach to meeting the needs of the practice population.

We saw areas of outstanding practice including:

- The provider employed focussed care practitioners, and one was based in the practice. GPs referred patients to the focussed care practitioner if their physical health needs were being addressed but they required more holistic help. Members of the team encouraged and motivated patients, helping with issues such as housing, debt, benefits and asylum applications and appeals, social isolation, attending appointments within secondary care and encouraging the uptake of health screening. We saw evidence of improved outcomes for patients.
- The practice was instrumental in setting up various social and support groups that supported the needs of the local population, focusing on those most vulnerable and or socially isolated. Some of these were organised and run by the practice and others were hosted by the practice in partnership with other health and social care providers. Groups included:
  - Women's group: A group which brought isolated women together with the aim of improving wellbeing, developing friendships and peer support within the community.
  - Men's group: A group set up to support isolated men and those who were struggling with addiction, who were identified as not thriving within the community. The group aimed to improve the men's wellbeing and provide friendship and improve self-esteem though the gardening and maintenance project Sheds and beds. Evaluation of the groups showed positive outcomes for those attending
- The practice had a food and equipment exchange initiative in place and were able to provide food parcels and household items to support patients in need. The practice also supplied 25 food hampers and 15 toy hampers to patients experiencing difficulties over the Christmas period.
- The practice employed in-house counsellors so they were easily accessible to patients. Staff were also actively encouraged to use the counselling service if they felt it was required.

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

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

Hollinwood Medical 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 second CQC inspector.

Background to Hollinwood Medical Practice

Hollinwood Medical Practice is the registered provider and provides primary care services to its registered list of approximately 3,982 patients. The practice delivers commissioned services under the Alternative Provider Medical Services (APMS) contract and is a member of Oldham Clinical Commissioning Group (CCG).

The APMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Hollinwood Medical practice is part of Hope Citadel Healthcare CIC which was set up with the aim of providing NHS services to those in under-doctored and deprived areas. They are a not-for-profit community interest company and offer whole person healthcare which they refer to as 'focussed care'.

Regulated activities are delivered to the patient population from the following addresses:

1 Clive Street

Oldham

Lancashire

OL8 3TR

The practice has a website that contains comprehensive information about what they do to support their patient population and the in- house and online services offered: www.hollinwoodpractice.org.uk

The age profile of the practice population is broadly in line with the CCG averages. Information taken from Public Health England placed the area in which the practice is located in the most deprived (from a possible range of between 1 and 10).

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The safeguarding lead GP also supported complex families, working with other health and social care professionals to monitor and coordinate care, including safeguarding and Common Assessment Framework (CAF) frameworks.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed, for example the practice introduced an advanced nurse practitioner to increase the availability of on the day appointments and treat minor ailments. The practice also employed a focused care worker and counsellor to support the holistic care provided to patients.
- There was an effective induction system for staff, including temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Clinical staff had recently attended an education session linked to identifying and managing patients suspected of having sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We found where appropriate detailed care plans were in place for vulnerable and older patients which addressed their physical, emotional and social needs.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.

Good

Are services safe?

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.
- The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a clear system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. All significant events were then investigated and discussed within the practice and where relevant they were also investigated and monitored by the provider Hope Citadel and learning shared across the whole organisation and with external agencies where appropriate.
- There were clear systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice.
- There was a provider wide system for receiving and acting on safety alerts which were then shared with the practice with details of actions required. The practice learned from external safety events as well as patient and medicine safety alerts.
- A practice business continuity plan was in place.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

There was a holistic, person centred approach to assessing, planning and delivering care and treatment to patients. The practice used innovative approaches to care including an understanding of the social and economic circumstances patients were living within, addressing these by developing a number of community groups and employing a focused care worker.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (01/07/2015 to 30/06/2016) was comparable to other practices in England.
- The number of antibacterial prescription items prescribed (01/07/2015 to 30/06/2016) was comparable to other practices England.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) was comparable to other practices in England.
- We saw no evidence of discrimination when making care and treatment decisions. Extended appointments were routine for vulnerable patients, those with poor mental health and patients requiring a translator to ensure time was available to assess often complex needs.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice held joint agency meetings to ensure coordinated care. The practice followed up patients discharged from hospital within three days. It ensured that their care plans and prescriptions were updated to reflect any changed needs and worked closely with social care regarding assessment for care packages.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Patients with complex needs and or multiple long term conditions were provided with extended appointments to ensure sufficient time to review and assess health needs and support patients to manage their own conditions.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three Royal College of Physicians (RCP) questions, was 82%. Comparable to other practices (CCG - 76%, National - 71%).
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was75% (CCG 76% and National 79%).
- The practice introduced a dedicated diabetic clinic lead by a GP and supported by the local diabetic team to improve outcomes for patients and provide care closer to home. In the first nine months 15% of patients had moved into the lowest HbA1c range.
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 92% (CCG 91% and National 90%)
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 82% (CCG and National 83%).
- The percentage of patients with atrial fibrillation in whom stroke risk had been assessed using the

Good

Are services effective?

(for example, treatment is effective)

CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) was 89% (CCG - 95%, National - 88%).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the standard target percentage of 90% or above in three areas:
  - Percentage of children aged 2 with pneumococcal conjugate booster vaccine was 96%
  - Percentage of children aged 2 with Haemophilus influenzae type b and Meningitis C booster vaccine was 96%
  - Percentage of children aged 2 with Measles, Mumps and Rubella vaccine was 98%
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There was a lead GP for children and families with complex needs. They worked with other health and social care professionals to monitor and coordinate care, including safeguarding and CAF frameworks.

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

- The practice's uptake for cervical screening was 82%, in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice offered all aspects of family planning, including contraceptive implants and coils.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice worked closely with social care and voluntary organisation to ensure a joined up approach to provide a holistic package of care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had alerts within patient's records which also indicated patients with carers.

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

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to other practices (national average 84%)
- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to other practices (national average 90%).
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 93%; CCG 92%; national 91%)

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results (2016/17) were 98% of the total number of points available compared with the clinical commissioning group (CCG) average and national average of 96%. The overall clinical exception reporting rate was 8% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. Monitoring and reviewing QOF and prescribing data as part of clinical meetings and using quality evaluation and quality improvement tools to monitor outcomes for patients.
- The practice was actively involved in quality improvement activity.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice introduced advance nurse practitioners into the practice in April 2017 to enable the practice to treat more patients with minor aliments on the day and reduce the numbers attending out of hour services and free up GPs to focus on patients with more complex needs.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. The practice was pro-actively working with other services such as the community matron, social workers, pharmacy, probation services, benefit agencies, the local council and voluntary organisations.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- Practice staff attended common assessment framework (CAF) meetings to ensure that families in difficulty received the multi-agency input they required to support them. We saw many examples of positive outcomes for disadvantaged children and children at risk due to the intense support provided by the staff at the practice.
- Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.
- 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway (practice 80%) was comparable to other practices in the CCG and nationally.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- A counsellor was employed by the practice and attended each week. They were flexible with the appointment times to enable patients who worked to attend.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- The practice was aware their patient demographic meant patients were at greater risk of long term health

Good

Are services effective?

(for example, treatment is effective)

conditions such as diabetes and hypertension. As a result they were working to identify at risk patients and provide education, care and treatment to those patients identified as having a long term condition.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- We saw examples where clinicians were engaged in best interest decisions where patients did not have capacity and notes of discussions and decisions were clearly documented.
- The practice monitored the process for seeking consent appropriately.

Outstanding ☆

Are services caring?

Our findings

We rated the practice as outstanding for providing caring services overall and across all population groups

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion and we saw numerous examples of where staff acted this out to support patients and where the practice actively encouraged this.

- Staff understood patients' personal, cultural, social and religious needs. The practice had a number of initiatives to ensure equality and access to care and treatment.
- Several community groups were run from the practice, with majority set up by practice staff such as groups for isolated/vulnerable men and women, asylum seeker groups as well as hosting initiatives such as Thriving Communities to help people back into work and Healthy Gems which targeted families with children under five years of age.
- The practice employed a focused care worker who supported patients in crisis as well as those in need of additional support in the community with social and emotional needs. We spoke with three patients who had been supported by the focused care worker who all told us of the positive impact they had had on their lives and the lives of their families.
- The practice arranged social events at Christmas and distributed food and toy hampers to vulnerable families.
- The practice gave patients timely support and information, as well as having dementia and carers champions in post, and promoted various community organisation.
- The practice had a food and household equipment resource bank which patients were able to access, we were provided with a number of examples of where families in crisis received food parcels donated to the practice as well as equipment for the home. We noted that one patient who was an asylum seeker was provided with a bike as a means of transport.
- The practice supported homeless patients and we were provided with one example of a patient who was able to access showering facilities in the practice until they were rehoused.
- 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.
- All of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients described the service they received as excellent and very good. They said the staff were professional, caring and friendly. Five of the 11 however also commented that it could be difficult to get an appointment with a specific GP and some GPs over run. The practice was aware of issues highlighted within the comment cards and was in the process of adapting the appointment system to address this. The results of the NHS Friends and Family Test indicated majority of patients were 'extremely likely' and 'likely' to recommend the practice to their friends and family.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 380 surveys were sent out and 93 were returned. This represented about 2% of the practice population. The practice were mostly comparable with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 79% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 79% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 84% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 94% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 85% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 93% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Outstanding ☆

Are services caring?

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- The practice wherever possible also ensured reviews and consultation for vulnerable patients were carried out by the same GP and were provided with extend appointments to establish a relationship and understanding of patients additional needs.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified (32) approximately 2% of patients as carers. We saw information for carers was readily available in the waiting area which was up to date and there was information on the practice website. One staff member acted as a carers champion within the practice and was active in ensuring information was up to date and identifying patients who may be carers.

- Staff told us that if families had experienced bereavement, the GP best known to the family contacted them. This call 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.
- A counsellor was employed by the practice and was able to provide bereavement counselling.

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

- 87% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 80% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 88% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences. The individual needs and preferences of patients were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met those needs and promote equality. This included people who were in vulnerable circumstances or who had complex needs.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours Saturdays 1pm to 5pm, online services such as repeat prescription requests, advanced booking of appointments, and advice services for common ailments.
- Appointments were routinely 13 minutes long, and there were longer appointments available for patients who required them including those with a learning disability or who required a translator. They also provided a dedicated GP lead clinic weekly for vulnerable patients as part of the practice focused care scheme.
- There was a dedicated GP for children with complex needs to promote continuity of care and wherever possible appointments would be made with the same GP for patients with poor mental health or complex needs.
- The facilities and premises were appropriate for the services delivered. The practice also had a community room and garden from which they delivered a range of groups and hosted community initiatives.
- The practice made reasonable adjustments when patients found it hard to access services, this included being referred to the focused care worker who would support patients one to one and if necessary attend appointments with patients.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice was also able to offer a full contraceptive service and minor surgery.
- The provider employed focussed care practitioners, and one was based in the practice, GPs referred patients to the focussed care practitioner if they their physical health needs were being addressed but they required more holistic help. Members of the team encouraged and motivated patients, helping with issues such as housing, debt, benefits and asylum applications and appeals, social isolation, attending appointments within secondary care and encouraging the uptake of health screening. We saw evidence of detailed care planning for these patients, and cases were regularly reviewed by the focused care worker and GPs. The focused care worker had on average 35 active cases seeing patients on a regular basis, but also provided emergency contact in-between appointments. We were provided with many examples of the positive impact the work had on patients and their families lives and data provided by the practice highlighted just some of the outcomes, for example in 2017, 12 patients attended for smear test who had previously refused, six homeless patients were rehoused, five supported through the Asylum process, successful reduced the reliance on emergency services with four patients and they supported 84 patients to receive appropriate benefits.
- The practice was instrumental in setting up various social and support groups that supported the needs of the local population, focusing on those most vulnerable and or socially isolated. Some of these were organised and run by the practice and others were hosted by the practice in partnership with other health and social care providers. Groups included:
  - Women's group: A group which brought isolated women together with the aim of improving wellbeing, developing friendships and peer support within the community. The group provided a range of creative activities and was facilitated by the focused care worker. Evaluation of the groups showed positive outcomes for those attending, including new friendship groups, improved self-esteem and improved self-care, which included many of the women attending for cervical screening which they had previously declined. Other outcomes included women returning to work or study.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Men's group: A group set up to support isolated men and those who were struggling with addiction, who were identified as not thriving within the community. The group aimed to improve the men's wellbeing and provide friendship and improve self-esteem though the gardening and maintenance project Sheds and beds. On average there were 20 men involved in the group and developing the garden space attached to the practice. We were provided with numerous example of the positive impact the project has had on those involved including sense of self-esteem, improved communication and new friendships developing as well as being more involved in managing their own health, attending reviews and increased uptake of flu jabs. The group has developed to the point where men from the group can work in the garden at any time, after some of the men involved in the group supported the practice to apply for funding for more gardening equipment including a greenhouse and shed. There was also a new spin off cookery sessions to teach basic cookery skills and enable them to enjoy the food grown within the garden.
- The practice hosted a 'Thriving Communities' programme in partnership with the local authority which supported people back into work. The practice also supported initiative such as adult learner's week.
- The practice were aware of the higher than average child poverty and poor health outcomes for children within the local area and so were partnering with the local authority to deliver a new group 'Healthy Gems' a health education programme targeting families with children under five years of age.
- A new group was also being developed in partnership with shared health to explore health education with asylum seekers and refuges locally, the practice were in the process of recruiting patients for this new group.

- The practice had a food and equipment exchange initiative in place and was able to provide food parcels and household items to support patients in need.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. GPs supported patients living within residential and nursing home by providing regular planned and unplanned visits, however many of the older people the practice supported were living in their own homes meaning many requiring home visits and support from the focused care worker to support those who were isolated and ensuring they had access to social care and community services.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, we noted these could be up to an hour with a nurse for those with the most complex needs. The practice requested relevant blood tests were performed in advance to ensure all clinical information was available to complete reviews. The multi reviews were also provided for housebound patients within their own home. Consultation times were flexible to meet each patient's specific needs.
- The practice had regular contact with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice worked to identify patients with long term conditions by actively screening patients and auditing records to identify any patients not showing on disease registers enabling them to provide appropriate care and treatment and support patients to lead healthier lifestyles.
- The practice targeted patients who failed to attend for or respond to requests to attend for reviews. They told us it is often those that don't attend who are in most need of care and treatment and they would utilise various means to engage patients including referral to focused care worker, home visits or opportunistic reviews as and when patients attended at the practice.

Families, children and young people:

- The practice was located in an area of high childhood deprivation with many young people who were not in education, training or employment and the practice were involved in a number of initiatives to improve

outcomes for families and children, for example Healthy Gems programme for children under 5 years of age, referrals to the focused care worker and access to the practice food and equipment share scheme.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 5 were offered a same day appointment or telephone consultation when necessary.
- There was a lead GP in post who worked with children and families with the most complex needs to ensure continuity of care and close working relationships with other health and social care colleagues supporting families.
- There were toys and books within the waiting area to keep children entertained in the surgery and there were changing and breast feeding facilities.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice was open from 8am to 6:30pm Monday to Friday and 1pm to 5pm Saturdays.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Minor surgery and a full contraceptive service were also available.
- Patients who required support with debt and money matters were able to seek support from the through Focused Care Worker and Christians Against Poverty (CAP), who were both able to provide support and signposting with housing and or benefit issues.

People whose circumstances make them vulnerable:

- In line with the ethos of the provider 'making invisible patients visible' the practice had a number of innovative programmes to engage the most vulnerable of patients including referrals to the focused care worker, access to a men's group (Sheds and Beds), a women's club, carers initiatives and an asylum seekers/refugee group. The most vulnerable patients supported through the focused care scheme were provided with a named GP who held dedicated weekly clinical sessions for those at risk.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice ethos was clearly displayed by all staff and the wide range of initiatives the practice had in place to welcome and improve the outcomes of those most vulnerable patients.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- There was a member of staff in post who was a dementia champion and they were working to improve facilities and the experience within the practice for those patients and their relatives who had dementia.
- Patients were able to access in house counseling and MIND provided a weekly drop-in session at the practice.
- The practice provided patients with poor mental health double appointments as standard to ensure sufficient time to support patients with often complex needs.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- There were lead GPs in place for complex families and those patients being supported via the focused care team and patients with poor mental health to ensure continuity of care.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages. Observations on the day of inspection and reviewing the appointment system

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

we found appointments were available on the day of the inspection and there was a range of appointments including on the day and pre bookable remaining for the week.

Of the 380 surveys were sent out and 93 were returned. This represented about 2% of the practice population.

- 83% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 75% of patients who responded said they could get through easily to the practice by phone; CCG – 73%; national average - 71%.
- 67% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 81%; national average - 84%.
- 68% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 64% of patients who responded described their experience of making an appointment as good; CCG - 72%; national average - 73%.

The practice used a range of methods to gather patient feedback which included internal surveys, questionnaires and the friends and family test. In light of the lower than average results the practice conducted a survey with patients to identify how they could improve access. They had started to address some of the concerns raised by patients via the national GP survey and feedback by introducing an advanced nurse practitioner who offered on the day appointments to treat minor ailments, and adapting the appointment system to offer more on the day access.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. There were 20 written and verbal complaints received in the last year. We reviewed four complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and had plans in place to carry out annual reviews of trends.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity, skills and inspired staff to deliver the practice strategy and address risks to it. Staff were motivated by managers and the provider Hope Citadel to provide person-centred care and support those most vulnerable patients, in line with the ethos 'making invisible patients visible'.
- Alongside the management team within the practice the practice was supported by the provider team and board of executive and non-executive board of directors within Hope Citadel.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were innovative in addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and there was evidence of innovative collaborative work with others to improve the quality of care and improve patients and their families' well-being.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, person-centred care and promote positive outcomes for patients.

- There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve priorities. Speaking with staff they were proud of the service they provided to patients, their families and the wider community. We saw evidence of a number of initiatives set up by the practice to benefit individuals and families which demonstrated their core values on a daily basis.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The practice planned its services to meet the needs of the practice population and they recognised the wider needs of the population they served, for example they were aware of the higher than average levels of child deprivation locally and set up initiative to address this, such as Healthy Gems and had a lead GP for children and complex families.
- There was a strong culture of improving outcomes for patients across the practice and this was reflected in their aims and objective.
- Staff were aware of and involved in the development and monitoring of the vision, they understood the values and strategy and their role in achieving them. They told us
- The strategy was in line with health and social priorities across the region and were aware of the local priorities and were instrumental in driving forward new developments within the local community to address some of the social deprivation issues which impact on patients health and well-being, for example, the focused care worker initiative set up by the provider has been picked up by CCGs locally and rolled out to other practice across Greater Manchester.
- The practice monitored progress against delivery of the strategy and had a quality improvement programme in place.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. We saw the staff had a shared purpose, to deliver positive outcomes for patients and encourage self-care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals
- The practice appraisal process for all staff included 360 degree feedback. 360 degree feedback is a system or

Are services well-led?

Outstanding ☆

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

process in which staff receive confidential, anonymous feedback from the people who work around them. Staff told us this was used in a supportive way. GPs also had an in-house and external appraisal. The in-house appraisals included a video consultation, with the patients' consent. GPs told us this was a useful learning tool and valued the learning opportunity. The focused care worker also had access to clinical and peer supervision. Staff were supported to meet the requirements of professional revalidation where necessary.

- Staff, including, GPs, nurses, focused care workers and counsellors were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- The practice leaders looked at ways to develop staff and provided numerous professional development opportunities for staff.
- There was a strong emphasis on the safety and well-being of all staff. Staff were able to access the counsellor employed by the practice.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. We saw a range of audits carried out by the practice and provider with learning disseminated across the whole organisation including an audit to ensure asthma patients were being treated in accordance with current guidance, minor surgery audits and a range of medication audits to ensure patients were being prescribed the most appropriate and cost effective treatment.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made included input from clinicians to understand their impact on the quality of care.
- There were clear systems and process in place with clinical leads in post for the most vulnerable patients with regular reviews of care and close working relationships with other health and social care providers to improve patient's outcomes and keep them safe.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.

Are services well-led?

Outstanding ☆

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

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice had a range of methods to gather patient feedback. In addition to the National GP survey data, friends and family and responding to comments on NHS choices they were in the process of establishing a new patient participation group. The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. They were in the process of setting up a new patient participation group (PPG); including a virtual PPG to involve patients who did not want to, or were unable to meet in person.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice website was well maintained and contained information about the service provided also a range of self care and health promotion information was available with links to local and national support organisations.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and initiated and collaborated with local organisations to improve outcomes for patients in the area. For example:

- The continued quality improvement programme which engaged staff at all levels
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- Plans were in place and funding had been secured by patients participating in the men's group to expand the garden to enable activities all year round including more DIY projects as well as continuing to develop more cooking activates. An area within the garden was also being developed to enable patients from different cultural/ethnic backgrounds to grow fruit and vegetables more familiar to them.
- The practice continued to explore innovative ways to offer holistic care for patients and their families, with new initiatives starting with asylum seekers and refugees and focused work with children under five years of age.
- The focused Care Worked developed by the provider had been expanded and was being delivered now across a number of areas of high deprivation within Greater Manchester.