Radbrook Green Surgery

Inspection report

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Date of inspection visit: 20 November 2018
Date of publication: 15/01/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

We previously carried out an announced comprehensive inspection at Radbrook Green Surgery on 6 November 2014. The overall rating for the practice was outstanding. The practice was rated as outstanding for providing caring and responsive services and rated good for providing safe, effective and well-led services. The full comprehensive report on the November 2014 inspection can be found by selecting the 'all reports' link for Radbrook Green Surgery on our website at .

This inspection was an announced comprehensive inspection carried out on 20 November 2018.

This practice is rated as Good overall.

The key questions at this inspection are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Good

Are services well-led? - Good

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff.
- The practice had systems, processes and practices in place to protect people from potential abuse. Staff were aware of how to raise a safeguarding concern and most staff had received safeguarding training appropriate to their role. However, not all of the required staff recruitment checks had been obtained prior to employment.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect. Patients felt genuinely cared for and spoke very highly of the care and treatment they received.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Some patients reported difficulties contacting the practice by telephone. The practice acknowledged the difficulties and were taking action to improve their systems and patient experiences.
- The practice worked closely with outside agencies such as nursing homes and charities in the local area to improve the care delivered.
- The practice actively worked with the patient participation group (PPG) to meet the needs of their patients. They told us that the practice leaders were very receptive, always listened to them and took any suggestions on board to improve the service for patients.
- Information to support patients with making a complaint was readily available.
- There was a focus on continuous learning and improvement at all levels of the organisation.

We saw an area of outstanding practice:

The practice provided several support groups and were involved in a number of social initiatives. These included a support group for carers of people with dementia, a bereavement group and a support group for people with chronic fatigue and Myalgic Encephalopathy (M.E). Patients had access to a community and care co-ordinator who assisted patients of any age in need of help, support and advice by offering a signposting service. This included advice regarding care, transport, benefits, financial support, local support groups, housing and social isolation. A befriending service was also available to those most vulnerable to loneliness and isolation and at risk of being admitted to hospital and losing their independence.

The areas where the provider **should** make improvements are:

- Ensure all staff complete outstanding essential training.
- Continue to review and improve telephone access to the practice.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

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

Population group ratings

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

Our inspection team

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

Background to Radbrook Green Surgery

Radbrook Green Surgery is a purpose built primary care medical centre located on the edge of Shrewsbury town in Shropshire. The practice is registered with the Care Quality Commission (CQC) as a partnership provider and holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice is part of the NHS Shropshire Clinical Commissioning Group (CCG) and is a teaching and training practice for GP Registrars and medical students to gain experience in general practice and family medicine.

The practice treats patients of all ages and provides a range of medical services and delivers regulated activities from this practice only. At the time of the inspection the practice had approximately 9,600 registered patients. The practice area is one of low deprivation when compared with the local and national averages. The practice has 52% of patients with a long-standing health condition compared to the local average of 56% and the national average of 54%. Twenty-seven percent of patients are aged over 65 compared to the local average of 25% and the national average of 17%. Unemployment levels are the same as the local average at 2% and lower than the national average of 5%. The practice population is predominantly white British (97%).

The practice staffing comprises:

- Five GP partners (four whole time equivalent WTE)
- Three salaried GPs (1.87 WTE)
- One advanced nurse practitioner and two practice nurses (1.87 WTE)
- Three health care assistants (1.92 WTE)
- One practice manager
- One part-time clinical pharmacist, funded by NHS England
- A team of 19 administrative and reception staff in addition to medical students

The practice opening hours are between 8.15am and 8pm on a Monday and from 8.15am and 6pm Tuesday to Friday. The practice is open once a month on a Saturday between 9am and 11am. Extended hours appointments are provided Monday evenings from 6pm to 8pm. The practice has recently become a member of a network of practices in Shropshire working together to offer patients extended access pre-bookable appointments in the evening, at the weekend and during bank holidays allowing patients to have more choice of where and when they wanted to be seen.

The provider is registered to provide the following regulated activities: Diagnostic and screening procedures, family planning, maternity and midwifery, surgical procedures and treatment of disease, disorder or injury.

Additional information about the practice is available on their website: www.radbrookgreen.co.uk

Requires improvement

Are services safe?

At our previous inspection we rated the practice as good for providing safe services.

Safety systems and processes

The practice had systems in place to keep people safe and safeguarded from abuse, although they were not being implemented effectively.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. GPs and nurses had completed the required level of children and adult safeguarding training. Most other staff had completed this or were in the process of completing an on-line safeguarding training module. Staff we spoke with were aware of the safeguarding lead and knew how to identify and report concerns of potential abuse.
- We saw vulnerable patients were flagged on the clinical computer system to alert staff for example, children on the child protection register.
- Reception staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) We saw the chaperone policy documented where staff should stand when providing a chaperone service and this was reflected in discussions we held with staff.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- We looked at the personnel files of five members of staff and found the practice had not carried out all the necessary recruitment checks on new staff. In particular, the practice had not obtained health declarations relating to the physical and mental fitness of staff to carry out their work or Disclosure and Barring Service (DBS) checks prior to employment. We were advised there had been some difficulties with obtaining DBS checks through the umbrella body. An umbrella body acts on behalf of the DBS to process criminal record applications for organisations. Following the inspection, we received confirmation that DBS checks had since been obtained for all staff that required one. One staff members application did not detail a full employment history however, evidence to support the gap in employment was later shared with us. The staff records we reviewed showed staff had received the required immunisations appropriate to their role, except for a health care assistant (HCA). However, following the inspection, we received confirmation that the provider had since obtained a copy of the status directly from the staff member.
- There was a system in place to manage infection prevention and control. The practice nurse was the infection prevention and control (IPC) clinical lead and had carried out an internal audit in May 2018. The report showed an overall compliance score of 100%. No issues had been identified however actions had been taken. For example, moisturising cream throughout the practice had been replaced and dated as none of the creams were previously dated.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe. A clinical specimen procedure was in place.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. Succession planning was in place for a senior partner who was due to leave the practice in December 2018. Partners shared tasks and business continuity had previously been successfully tested in 2016 when two key leaders were off work due to significant unforeseen circumstances. A salaried GP had recently been recruited and there were plans to recruit additional staff to meet patient demand and the increase in registered patients.
- There was an induction system for temporary staff.
- The practice was equipped to deal with medical emergencies and all but three staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians we spoke with knew how to identify and manage patients with severe infections including sepsis. We saw information about sepsis, stroke and associated symptoms was readily accessible to patients and staff

Requires improvement

Are services safe?

- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals. The practice had a designated member of staff responsible for managing referrals. All referrals were sent to the local Clinical Commissioning Group referral assessment service (RAS). At the time of the inspection the practice was up to date with patient referrals.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Antibiotic prescribing was below local and national averages and had been discussed during a prescribing meeting recently held.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The practice kept prescription stationery securely and since the last inspection had made improvements to monitoring its use.

Track record on safety

The practice had a good track record on safety.

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

Lessons learned and improvements made

The practice learned from and made improvements when things went wrong.

- Staff understood their duty and were encouraged to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice had a GP lead for dealing with significant events and all of the staff we spoke with demonstrated a clear understanding of the process and were able to share examples of significant events. Designated meetings were held to discuss events and share learning.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice had effective systems in place for acting on external safety events, for example, patient and medicine safety alerts. Searches were carried out for any patients on any identified medicines or devices and affected patients were contacted and recalled for consultation.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

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 patient needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Patients over the age of 75 years had a named GP.
- GPs provided dedicated visits to two local nursing homes to review the residents registered with the practice and participated in the care homes advanced scheme (CHAS). A GP led proactive approach to the care of the residents to reduce the number of admissions into A&E and improve patient outcomes. They also provided medical cover for six step-down beds for the locality in addition to four continuing health care (CHC) funded beds.
- Patients had access to a community and care coordinator service whose role had developed to assist the frail elderly with access to services.
- Frail and vulnerable patients were identified and discussed in regular meetings held with the district nurses. They received a full assessment of their physical, mental and social needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

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. The practice had introduced an annual birthdate recall with all tests in one appointment and combined chronic disease follow up of linked conditions to reduce patients having to attend the practice for multiple appointments. 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.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice's performance on quality indicators for long term conditions was in line with local and national averages. However, the practice exception reporting rate was higher than the CCG and the national averages, meaning fewer patients had been included. Following the inspection leaders sent us a comprehensive action plan to address this issue with specific actions to explore the reasons and put in place processes to address any areas of risk,

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%. The practice had achieved between 95% to 99% for the four indicators.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice provided three fully accredited family planning trained GPs to run the family planning service provided.

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

- The practice's uptake for cervical screening was 79.9%, which was in line with the 80% coverage target for the national screening programme, and above local and national averages. Two nurses and three female GPs were trained to undertake cervical cancer screening. Appointments were available Monday to Friday to include Monday evening for working women.

Good

Are services effective?

- The practice's uptake for breast cancer screening (84%) was above the local average of 80% and the national average of 70%. Bowel screening uptake was 70%, which was above the local average of 61% the national average of 55%.
- Patients had access to appropriate health assessments and checks including NHS checks and checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice attended meetings with external health professionals to ensure those who were approaching end of life had a cohesive plan of care.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had a GP lead for patients with a learning disability who co-ordinated annual assessments. Good links had been developed with the local learning disability facilitator who helped the practice co-ordinate their register and provide advice and assistance to include mental capacity decisions.
- Information of concern regarding patients who failed to attend their secondary care appointments was forwarded to a staff member who checked for any history of dementia, frailty, increased vulnerability and followed up the patient after discussions with their colleagues.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease and cancer and access to 'stop smoking' services. The practice had started to collaborate with a new social prescribing (healthier lives) service managed by the local authority to help patients who were unable to move forward in their health due to other circumstances.
- There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. Patients had access to an on-site counsellor who was funded by the local clinical commission group.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practices performance on quality indicators for mental health was comparable with local and national averages. However, the practice exception reporting rate was higher than the CCG and the national averages in two of the three clinical indicators.

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.

- 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 for 2017/18 showed the practice had achieved 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and the national average of 96%. The practice exception reporting was 16% compared to the local and national averages of 10%.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

Good

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- 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 team had a diverse mix of skills and leaders understood the learning needs of staff. However, a number of staff were not up to date with all of their essential training. Staff were encouraged and given opportunities to develop and enhance their skills. For example, a former apprentice had become a key member of the reception team and now trained new recruits. A member of the nursing team had been supported to complete a two-year nurse practitioner day release course and a further nurse had just commenced a 12-month nurse prescriber course
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice carried out regular health and medication reviews at local nursing homes to include care homes advanced scheme assessments. The advanced nurse practitioner carried out annual health checks of patients who were housebound.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. Meetings were held with external healthcare partners to discuss patients with complex needs. The practice also liaised with the local hospice.

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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through a local social prescribing scheme where patients were invited to meet with a social prescribing advisor to discuss their health and wellbeing needs and develop an action plan to achieve their goals.
- 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, tackling obesity.
- With the support of the patient participation group (PPG) the practice had obtained nine blood pressure machines and monitors that enabled patients to monitor their blood pressure in the comfort of their own home for a specified time. Copies of an eight-week blood sugar diet book had also been obtained for patients identified with pre-diabetes.

Consent to care and treatment

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

Good

Are services effective?

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Written consent was obtained for child immunisations, contraceptive implants, coils and minor surgery.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was very positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

The practice had a carer lead to assist patients in the need of help, support and advice by signposting them to other useful services. The practice provided a range of support groups for patients to access, including patients who were not registered at the practice. For example, a bereavement group and two Myalgic Encephalopathy (M.E) support groups. The practice had a community and care co-ordinator who was funded part-time by the local Clinical Commissioning Group (CCG). They assisted patients of any age in need of help, support and advice by offering a signposting service. This included advice regarding care, transport, benefits, financial support, local support groups, housing and social isolation. The practice was also involved in a social initiative befriending service to help those most vulnerable to loneliness and isolation and at risk of being admitted to hospital and losing their independence.

Carers we spoke with during the inspection shared positive experiences of how well they had been supported by staff at the practice. They told us the practice were very attentive to their needs and had regularly visited their relatives at home to review their health needs as they were unable to get to the practice. Patients commented that staff were professional, kind, helpful and very caring. Many patients described their care and treatment as outstanding, excellent and first class. Managers from two local nursing homes told us the visiting clinicians genuinely cared for the health needs of their residents.

The practice provided water, tea and coffee facilities in the waiting area for patients to help themselves to when attending the practice.

The results of the National GP patient survey, published August 2018, showed the practice was in line or above local and national averages for questions relating to kindness, respect and compassion.

- Two hundred and thirty surveys were sent out and 111 were returned giving a completion rate of 48%. Results showed 90% of patients who responded said the healthcare professional they saw or spoke to at their last appointment was good at treating them with care and concern; compared with the local average of 92% and the national average of 87%.
- Ninety-two percent of patients who responded said the healthcare professional they saw or spoke to at their last appointment gave them enough time; compared with the local average of 91% and the national average of 87%.
- One hundred percent of patients who responded said they had confidence and trust in the last healthcare professional they saw; compared with the local average of 97% and the national average of 96%.

Involvement in decisions about care and treatment

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

- We saw the new patient health questionnaire required new patients to identify if they had any communication needs and a hearing loop system was available at the reception desk to assist patients with a reduced range of hearing. Information in larger print was made available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice pro-actively identified carers and offered flexible appointment times and invited carers for flu vaccinations and a health check for those aged 40-74 years. Other health issues relating to carers were passed to clinicians by the community and care co-ordinator for review.
- The practices GP patient survey results for 2018 were above local and national averages for questions relating to involvement in decisions about care and treatment. Ninety-eight percent of patients who responded said

they were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment; compared with the local average of 96% and the national average of 93%.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services with the exception of people whose circumstances may make them vulnerable which we rated outstanding.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone and face to face appointments were available throughout each day via the duty doctor which supported patients who were unable to attend the practice during normal working hours.
- Standard appointments were 15 minutes in duration and patients were not limited to discussing only one concern. Double appointments were available for vulnerable patients or those with complex conditions. Salaried GPs had a reduced patient list to facilitate continuity of care.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- A patient messaging service was used to remind patients of their appointments.
- The practice had recently become a member of a network of local practices working together to offer patients extended access pre-bookable appointments in the evening, at the weekend and during bank holidays.
- Patients were able to order their repeat prescriptions through prescription ordering direct (POD) which they were able to use in the comfort of their own home, avoiding patients having to go into the GP practice or pharmacy.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- Elderly frail and vulnerable patients were identified and coded on the clinical system and discussed in monthly meetings held with the district nurse.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs. The advanced nurse practitioner carried out annual health checks of patients who were housebound.
- The practice provided a weekly ward round to two local nursing homes to review residents' health needs. They also provided medical cover for six step-down beds for the locality in addition to four continuing health care (CHC) funded beds.

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 during one appointment, reducing the number of appointments patients had to attend the practice.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice offered prevention and chronic disease health education advice and events and provided patients with information on self-help groups.
- Pre-diabetic patients were identified and referred to the national diabetes programme to help educate patients on lifestyles to help prevent progression to diabetes. Educational books on preventative care for patients with prediabetes were available for loan.

Families, children and young people:

- The practice had 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.
- Parents or guardians concerned about a child were offered a same day appointment when required.
- Antenatal clinics were held by appointment in addition to a full family planning service.
- The practice provided dedicated child immunisation clinics on a Monday and Thursday but were flexible in providing appointments outside of these clinics.

Good

Are services responsive to people's needs?

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, extended access appointments were offered as a priority to working age patients on a Monday evening from 6pm to 8pm.
- Telephone consultations were available via a duty doctor which supported patients who were unable to attend the practice during normal working hours.
- The practice provided on-line services for example booking of appointments and repeat prescription ordering. An electronic prescription service (EPS) was also available.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had a designated learning disability GP lead and worked with the local learning disability facilitator in identifying patients with a learning disability, provided advice and assisted patients to attend annual reviews where required.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. A local charity for the homeless supported the practice with contacting patients and arranging follow up health appointments.
- The practice had a designated member of staff who assisted patients of any age in need of help, support and advice by offering a signposting service. This included advice regarding care, transport, benefits, financial support, local support groups, housing and social isolation. The practice also provided a befriending service for lonely or vulnerable patients.
- The practice held monthly dementia carer's support group meetings.

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.
- Staff had access to a mental health link worker who visited the practice once a week to see patients with acute mental health issues. A counsellor was also available.
- The practice had started to collaborate with a new social prescribing (healthier lives) service managed by the local authority to help patients who were unable to move forward in their health due to other circumstances.

Timely access to care and treatment

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.
- Patients reported that the appointment system was easy to use however, some patients said they experienced difficulties getting through to the practice by telephone. The provider acknowledged the difficulties and were working to address the issue.

Results from the national GP patient survey, published in August 2018, showed that patients' satisfaction with how they could access care and treatment was in line or lower than the local and national averages.

- Seventy-eight percent of patients who responded described their experience of making an appointment as good; compared with the local average of 76% and the national average of 69%.
- Sixty-one percent of patients who responded said they were offered a choice of appointment; compared with the local average of 67% and the national average of 62%.
- Eighty-one percent of patients who responded said they were satisfied with the type of appointment they were offered; compared with the local average of 79% and the national average of 74%.
- Sixty-three percent of patients who responded said they found it easy to get through to the practice by telephone; compared with the local average of 83% and the national average of 70%.

The practice acknowledged that patients had experienced difficulties with getting through to the practice by

telephone and were working with the service provider to resolve the problem. The practice had commissioned two external call handlers four hours in the morning to assist with demand and were also promoting online services for patients to register and book appointments. The practice's own patient survey had identified a need to improve telephone access and the provider had developed an action plan to address the findings and carried out their own telephone audits and were keeping this under review.

Listening and learning from concerns and complaints

The practice had a culture of reporting and recording all informal and formal complaints and took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to share comments, compliments and complaints was detailed in the new patient information leaflet, at the practice and on the practice website.
- The practice learned lessons from individual concerns and complaints to improve the quality of care. Complaints were discussed in practice meetings held to share learning.
- Staff treated patients who made complaints compassionately.

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice had a clear vision in place. This was to recognise patients' lifelong health needs with an aim to treat each patient as an individual; combining excellent up-to-date innovative skills with traditional service values. The mission statement and practice ethos had been developed with staff and staff we spoke with were aware of practice vision and values and told us they strived to put patients first and help to find solutions.
- Practice leaders were able to explain their strategy and following the inspection forwarded us a documented business plan to support their vison and strategy and achieve priorities.
- The practice planned its services to meet the needs of the practice population.

Culture

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

- The practice had an established staff team. Many staff told us they were proud and very privileged to work at the practice and felt extremely supported by the practice leaders. A registrar we spoke with told us they were very much supported in their work at the practice and felt a valued member of the team.
- The practice focused on the needs of patients.
- 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 there was an open culture of reporting and sharing information They told us they were able to raise concerns and were encouraged to do so.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff felt they were treated equally and most staff had received training in equality and diversity.
- 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 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 policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, there was a lack of oversight of safe recruitment processes, which was acknowledged by the practice manager and assurances provided this would be addressed. An updated recruitment policy was sent to us following the last inspection.
- The practice had a clear organisational structure and staff had allocated lead roles and responsibilities.

Managing risks, issues and performance

Good

Are services well-led?

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments. Leaders were constantly reviewing their workforce plans to meet the needs of their patient population and had succession plans in place.

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.
- 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 submitted data or notifications to external organisations as required.
- There were effective 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. There was an active patient participation group (PPG) that consisted of eight core members. A representative of the group told us that the practice leaders were very receptive, always listened to them and took any suggestions on board to improve the service for patients.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- Leaders encouraged continuous development of staff roles and many staff had been promoted within the practice.
- 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.
- The practice had recently become a member of a network of local practices working together to offer patients extended access pre-bookable appointments in the evening, at the weekend and during bank holidays.
- The practice was a training practice for GP Registrars and medical students to gain experience in general practice and family medicine.

Please refer to the evidence tables for further information.