Manor House Surgery

Inspection report

1 Mill Lane
Belton
Loughborough
Leicestershire
LE12 9UJ
Tel: 01530 222368
www.beltonsurgery.nhs.uk

Date of inspection visit: 10 October 2018
Date of publication: 14/12/2018

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Manor House Surgery on 10 October 2018 as part of our inspection programme.

At this inspection we found:

- There was an effective system in place to deal with safeguarding and staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. When incidents did happen, the practice learned from them and improved their processes.
- 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.
- Patient satisfaction with access to care and treatment was considerably higher than average and the practice had significantly reduced avoidable appointments over the last year resulting in increased appointment availability.
- Where relevant patients were given hand held records to keep with them relating to their condition and care plan. These were highly detailed and personalised and demonstrated a commitment to delivering high-quality personalised care.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

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

- Improve the system for monitoring training to ensure there is oversight of training requirements.
- Continue to monitor the cold chain process to ensure temperatures of vaccine refrigerators are monitored appropriately.
- Develop the system for reviewing policies to ensure they are up to date and reflect current practice.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief 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	Good
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 adviser, a practice manager specialist adviser and a second CQC inspector.

Background to Manor House Surgery

Manor House Surgery is a GP practice providing primary medical services under a General Medical Services (GMS) contract to around 4,000 patients. This is a contract between general practices and NHS England for delivering services to the local community. The practice is able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy and dispense to over 90% of their patients.

The registered provider of services is Dr MJ Aram & Dr IJ Gordon and they are registered to deliver the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. The provider is registered with CQC to deliver these services from one location; Manor House Surgery at 1 Mill Lane, Belton, Loughborough, Leicestershire. LE12 9UJ which we visited as part of our inspection.

Belton is a village, seven miles west of Loughborough and the practice serves this and a number of other surrounding villages. The practice is housed in a single storey purpose built property which was refurbished and extended between 2015 and 2016. There is disabled access to the ground floor and a car park which includes designated spaces for the disabled. The practice's services are commissioned by West Leicestershire Clinical Commissioning Group (WLCCG). The practice is part of North West Leicestershire GP Federation.

The practice population has a lower than local and national average of patients over the age of 75 and a higher than average number of patients aged 65 to 74. The National General Practice Profile states that 98% of the practice population is of white ethnicity. Information published by Public Health England, rates the level of deprivation within the practice population group as eight, on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male life expectancy is 81years compared to the national average of 79 years. Female life expectancy is 88 years compared to the national average of 83 years.

The practice has two full time GP partners; one male and one female. There are two part-time practice nurses, a health care assistant and a phlebotomist (who also works on reception). There is also a team of dispensers. They are supported by a practice manager, an assistant practice manager and a team of administrative and reception staff.

Manor House Surgery is open from 8am to 12.30pm and 1:30pm to 6:30pm 13.30-18.30 Monday to Friday with

telephone lines being manned from8am to 6.30pm each day. Extended hours appointments are also available to all patients at additional locations within the area as the practice is within West Leicestershire CCG area. From 6.30pm to 8am Monday to Friday and all weekend, out of hours services are accessed by calling the NHS 111 service.

The practice website can be found .

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- 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.

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.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. We saw evidence of examples when these arrangements had been successfully implemented.

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 including sepsis. The reception team had received Sepsis Awareness Training to enable them to identify possible signs of Sepsis. This was also promoted in a recent staff newsletter. There were posters relating to sepsis displayed in the reception area to raise awareness amongst patients.

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 in line with protocols.

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. The practice had identified that there were gaps in vaccine refrigerator temperature recording and had acted to change the process to avoid a reoccurrence.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current local and national guidance.
- The practice were slightly higher than the local and national average for antibiotic prescribing and had reviewed this to support good antimicrobial stewardship in line with local and national guidance. We saw that the practice were carrying out audits to monitor this.
- 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.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

Good

Are services safe?

- There were some comprehensive risk assessments in relation to safety issues. Other risks had been assessed but not documented. These were documented and provided immediately after our inspection.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty 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 learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

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* 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:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients at risk of emergency admissions were given care plans or patient summaries.
- The practice followed up on older patients discharged from hospital. The practice contacted patients within 48 hours of receiving their hospital discharge letter. They then ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. All clinicians had received training on Mental Capacity Act and Deprivation of Liberty.
- Continuity of care was promoted by the fact the practice was relatively small, GPs and staff were familiar with patients and their families and patients had a named GP.
- Wherever possible the practice operated a 'one stop visit' system to co-ordinate GP reviews and nurse appointments for patients.
- The practice offered a seasonal vaccination programme for older people.
- Information on Carers, next of kin and preferred contact methods were included in referral letters.

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.
- GPs followed up patients who had received treatment in hospital or through out of hours services relating to their long-term condition.
- 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.
- Where appropriate emergency prescriptions were issued to respiratory patients.
- Long term conditions clinics were combined to minimise the number of different appointments for patients with multiple conditions.
- The practice used community specialist nurses to provide care for patients with complex conditions such as diabetes, respiratory conditions and heart failure.
- Monthly meetings were held to discuss patients needing additional support such as end of life care.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%, in the majority of areas they practice had achieved 100% uptake.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and the lead GP for safeguarding worked closely with Health Visitors and the Midwife to identify and monitor vulnerable families.

Good

Are services effective?

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

- The practice's uptake for cervical screening was 77%, which was below the 80% coverage target for the national screening programme. However, this was in line with the local average and above the national average. The practice had worked to improve this coverage and unverified data provided by the practice on the day of our inspection indicated that the achievement for the current year was already 81% against a target of 80%.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS 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.
- The practice offered annual aneurysm screening.

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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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, cancer and access to 'stop smoking' services. 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 at risk of dementia were identified and offered an assessment using a 'dementia toolkit' to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. Staff had received training about dementia.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages.

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 practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity.

Effective staffing

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

- 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 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. However, we found that there were some gaps in refresher training which the practice manager told us would be addressed. Staff told us they were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included, appraisals, coaching and mentoring, clinical supervision and revalidation.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Good

Are services effective?

Coordinating care and treatment

Staff worked closely 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 those requiring end of life care. They shared information with, and liaised, with community services, social services and carers for housebound patients and those with long term conditions.
- 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. We found that patients were given hand held records to keep with them relating to their condition and care plan. These were highly detailed and personalised and demonstrated a holistic approach to care.
- 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.

Staff encouraged and supported patients to be involved in monitoring and managing their own health.

- 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. Referrals were made into local community health education services such as Active Lifestyle, Stop Smoking, and the Diabetes Empower education programme.

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 that the practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was extremely 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 practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

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.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were 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 proactively identified carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff were able to offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

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. The practice had made patients' needs and preferences central to the planning and delivery of its services and had designed their systems and processes to accommodate needs and empower patients.

Responding to and meeting people's needs

The practice proactively 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 GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice actively participated in research schemes which they considered would provide benefits to patients and the wider community.
- The facilities and premises were appropriate for the services delivered and investment had been made in the building recently to allow refurbishment and modernisation.
- Reasonable adjustments were made when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have 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.
- The practice provided dispensary services for people who needed additional support with their medicines including a delivery service for housebound patients, remote collection points and the provision of monitored dosage systems.
- All patient interactions were viewed as an opportunity to consider patients' care and treatment needs. For example, as the practice dispensed medicines to over 90% of their patients, dispensary staff saw many patients who collected medication monthly. They used this as an opportunity to invite them for seasonal vaccinations, long term condition reviews or blood tests as appropriate.
- One of the GP partners had introduced a system to ensure patients understood their condition and what their medication was for. When the medication was dispensed the labelling was personalised to include information advising the patient what the medication was and why they were taking it in layman's terms. For example, one label stated, one tablet at bedtime to treat high blood pressure and protect kidneys in diabetes. This system empowered patients and was particularly helpful to patients who were on multiple medicines so that they understood how the medicines interacted with each other.
- The practice provided information for patients with their medication detailing any monitoring required in respect of their medicine. We saw that this was personalised for each patient.
- Following a significant event regarding a two week wait referral, one of the GP partners identified that there was an issue with the system for two week wait referrals received at the local hospital. They worked with the CCG and as a result the system for dealing with two week wait referrals at the hospital changed, improving the system for patients.
- The practice fully engaged with their federation and all staff embraced new initiatives. One such initiative was Active Signposting which was one of the 10 High Impact Actions identified by NHS England. In the last year the practice had trained staff in Active Signposting and alongside the training they had promoted signposting through various means including patient newsletters and information in the practice and on the website. There were articles in the monthly staff newsletter to remind staff of opportunities for signposting and these were tailored to the season such as a reminder about options for signposting to pharmacies for advice regarding hay fever in the summer.

The practice also organised a treasure hunt around the local area for staff during a training afternoon which was used to highlight local options for signposting. The way in which all staff had embraced the initiative combined with the use of telephone consultations where appropriate had resulted in a reduction in avoidable appointments from 28% to 14% of book on the day appointments from December 2017 to September 2018. One of the education events organised by the PPG promoted active signposting and was attended by a local pharmacist to educate patients about the services they could offer.

Older people:

Good

Are services responsive to people's needs?

- All patients had a named GP who supported them in whatever setting they lived and patients were aware who their named GP was.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Longer appointments were available when required due to the flexible appointment system.
- Patients with specific needs were given a 'passport' for weekend access to their local GP.
- The practice offered a dispensary service with a medicines delivery service for housebound patients and two remote collection points to avoid unnecessary journeys for older patients.

Home visits were triaged by a telephone call with the GP to establish whether a visit should be made and if so whether by the practice GP or the local Acute Visiting Service team.

- The practice operated 'one stop' visits for GP reviews and nurse appointments wherever possible so that older patients did not have to make multiple appointments.
- Information on Carers, next of kin and preferred contact methods were included in referral letters.
- Seasonal vaccinations were delivered at the same time as other appointments where possible.
- All facilities were on the ground floor of the practice so could be accessed by patients in wheelchairs or those with less mobility.

People with long-term conditions:

- There was a proactive recall system for annual reviews and medication reviews which meant patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice combined clinics which enabled multiple conditions to be reviewed at one appointment.
- Consultation times and types of appointment were flexible to meet each patient's specific needs.
- The practice were in regular contact with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice offered a dispensary service and this included a medicines delivery service for housebound patients.
- There were two remote collection points from where patients with long term conditions could collect their repeat prescriptions.
- The practice used community specialist nurses to provide care for patients with complex conditions such as diabetes, respiratory conditions and heart failure.
- The practice encouraged home monitoring of blood pressure and could loan machines if necessary.
- Quarterly patient education events were offered in conjunction with the PPG and previous events had included sessions related to long term conditions such as diabetes.
- Seasonal vaccinations were delivered at the same time as other appointments when possible.

Families, children and young people:

- We found that the Safeguarding Lead worked closely with Health Visitors and the Midwife to identify and monitor vulnerable families. 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 were offered a same day appointment when necessary.
- The practice was proactive in contacting parents to ensure they brought their children for immunisations which resulted in very high childhood immunisation rates.
- The practice offered flexible appointments for young adults which included telephone triage.
- Breastfeeding was promoted in the practice.
- The premises were accessible for prams and pushchairs.
- The GP partners undertook baby checks 24 hours and six weeks after the birth.

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.

Good

Are services responsive to people's needs?

- Extended hours appointments in the early morning, evenings and at weekends could be offered to patients at additional locations within the West Leicestershire area as part of the service provision by West Leicestershire CCG.
- Access to online services was actively encouraged.
- The practice offered a range of travel vaccines.
- The practice offered annual aneurysm screening.
- Seasonal health advice and educational information was available in the patient waiting room.
- Quarterly patient education events were offered in conjunction with the PPG and previous events had related to active signposting and self-help information for patients. This was supported by links available on the practice website to self-help programmes.
- The practice website was easy to navigate and held a wide range of information and guidance.

People whose circumstances make them vulnerable:

- The practice held a register of patients with learning disability and other circumstances that could make them vulnerable. This was regularly reviewed by the Safeguarding Lead GP.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Annual health checks were carried out for patients with learning disabilities.
- Telephone triage and flexible appointments were available.
- Patient records of vulnerable patients were flagged to identify specific needs to staff.
- A link was included in patient records to their carers information.
- The practice included patients' preferred methods of communication in referral letters.
- Access to interpreters was available for patients whose first language was not English.

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. The practice had organised a training and information session run by the Alzheimer's Society. This provided staff with a greater understanding and information about dementia support. Patients had also been invited to attend.
- The practice worked in conjunction with local community services to support patients' mental health needs.
- There was a self-referral system into the Improving Access to Psychological Therapies (IAPT) service for patients experiencing poor mental health.
- Telephone appointments were offered where appropriate for patients who were experiencing poor mental health and may have found it difficult to attend the practice.
- The practice used a dementia toolkit to help capture diagnoses of dementia.
- Continuity of care and choice of GP was provided.

Timely access to care and treatment

Patients could access appointments and services in a way and time that suited them. The flexibility of the appointments system meant that patients could be seen on the same day when necessary.

Patients had timely access to initial assessment, test results, diagnosis and treatment.

- Waiting times, delays and cancellations were minimal and were managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported very positively that the appointment system was easy to use and that they were extremely satisfied.
- The combination and flexibility of telephone, on the day and pre-bookable appointments during morning and afternoon clinics enabled longer appointments where needed.
- The practices GP patient survey results were considerably higher than local and national averages for questions relating to access to care and treatment, with the practice scoring 90% or above in this area.
- The practice had carried out capacity and demand audits of the appointment system and continually monitored the appointment system to ensure that there were always sufficient urgent and non-urgent appointments available on a daily basis.

Listening and learning from concerns and complaints

There was an active review of complaints and how they were managed and responded to. Improvements to the

Good

Are services responsive to people's needs?

quality of care were made as a result. Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

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 and the GP partners and the practice manager demonstrated inclusive and compassionate leadership which created a supportive and motivated working environment.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The leaders embraced new initiatives and we saw that they had motivated staff to fully engage with them to improve the service provided.
- Leaders at all levels 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.
- We saw that the leaders had an inspiring shared purpose and motivated staff to

succeed.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The ethos of the practice was to provide high quality, safe and effective healthcare in a confidential and friendly environment with a focus on personalised patient-centred care.
- Staff were committed to and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care. The leaders had an inspiring shared purpose and there were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were encouraged to raise concerns.

- Staff stated they felt respected, supported and valued and were proud to work in the practice.
- The practice focused on the needs of patients.
- 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 had received an appraisal in the last year. 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.
- There were positive relationships between staff at all levels with a strong team spirit and support for each other.
- There was strong collaboration and support across all staff and a common focus on

improving quality of care and people's experiences.

- All staff were committed to and involved in providing person-centred care. This was enhanced by the fact that a high percentage of staff were long standing and had a good knowledge of patients and their families and this in turn promoted continuity of care.
- There were effective lines of communication within the practice both on a day to day basis and through structured meetings. These included multidisciplinary team meetings, clinical meetings, nurse meetings, partners meetings, dispensary meetings and reception staff meetings. These were all comprehensive and clearly minuted.
- The practice organised many social events for staff and considered their needs. For example, when the refurbishment of the practice had been completed, the

practice gave ownership of an outside courtyard area to staff, for use during breaks and all staff members were given a sum of money to spend as they wished to purchase items for the area such as plants, bird feeding facilities and garden furniture. Staff regularly came in to the practice outside of working hours to maintain the area.
- The partners had recently introduced a weekly fruit delivery for staff to encourage healthier eating.

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. Some policies we viewed required updating but the practice provided the updated versions after our inspection.

Managing risks, issues and performance

There were 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.

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 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. There was an active patient participation group who worked with the practice to provide quarterly education events for patients.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice used social media campaigns to bring items of interest to patients, not only information from themselves but from the CCG or NHS England. Some of the younger members of staff had been encouraged to take responsibility for managing this form of communication.
- The practice produced a monthly staff newsletter and a patient newsletter every two month. These contained a wealth of information and were also used to inform and promote any current initiatives the practice were involved in.

Good

Are services well-led?

- The practice organised a tea party in July 2018 and invited patients to join staff to celebrate the 70th anniversary of the NHS. Patients and staff were asked to make a pledge to use NHS services wisely. These pledges were displayed in the patient waiting area.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement and staff were supported and encouraged to develop.
- 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.
- We were told the practice were actively involved in the local federation of GP practices with one of the GP partners being the vice chair and the practice manager led the federation practice managers forum.
- The practice were part of a cohort within the local federation of GP practices and this enabled opportunities for training and shared learning.
- A 'Best prescribing award within the locality' had been awarded to the practice for the past two years by the federation.

Please refer to the evidence tables for further information.