Castleford Medical Practice

Inspection report

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

Ratings

Overall rating for this 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 overall. The practice was previously inspected on 27 June 2016 and was rated as Good overall.

The key questions 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 Castleford Medical Practice on 5 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had 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. We did however identify that processes in relation to the receipt and actioning of medicines safety alerts did not give assurance that all alerts had been identified or actioned.
- 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.
- The practice had a systematic approach to service improvement and had introduced new processes and working practices when they identified areas of below average performance or when patient satisfaction was low. For example, they offered open access appointments on a Monday 8am to 10am when patients who called the surgery received an appointment that day.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Review and improve the practice's processes in relation to the receipt and actioning of medicines safety alerts to ensure that all relevant alerts are received and necessary actions taken.
- Review and improve portable appliance electrical testing procedures to ensure that all equipment is tested at required intervals.
- Review and improve the level and detail of information contained in staff personnel files to include information with regard to staff immunity status.
- Keep under review the ongoing structural issues regarding the fabric of the practice building.

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

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 CQC lead inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to Castleford Medical Practice

The Castleford Medical Practice is located in the Health Centre on Welbeck Street Castleford, West Yorkshire, WF10 1HB. It currently provides services for around 5,900 patients. The practice is a member of the NHS Wakefield Clinical Commissioning Group (CCG.)

The practice is located in the town centre of Castleford and is located close to public transport being adjacent to the bus and railways stations. The practice shares a 1960s build health centre with another GP practice, a number of other community health services including school nurses and podiatry, and an independent pharmacy. General premises maintenance and upkeep is via NHS Property Services. Limited parking spaces are available outside the surgery, although a public car park is also located close to the health centre. The main reception and consultation rooms are located on the ground floor and are accessible to those with a physical disability.

The practice population age profile shows that it is slightly above that of the CCG and England averages for those over 65 years old (19% of the practice population is aged over 65 as compared to the CCG average of 18% and the England average of 17%) and 68% of the practice population report having a long standing health condition compared to a CCG average of 57% and an England average of 54%. The practice is located in an area of relative deprivation being ranked in the third most deprived decile. The practice population is predominantly White British (98%).

The practice provides services under the terms of the Personal Medical Services (PMS) contract. In addition to this the practice offers a range of enhanced local services including those in relation to:

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Rotavirus and Shingles immunisation
- Learning disability support
- Dementia support
- Minor surgery

As well as these enhanced services the practice also offers or hosts additional services including:

- Chronic illness management clinics for conditions such as asthma and diabetes.
- Joint injections
- Health checks
- Weight management
- Smoking cessation
- Audiology
- Ultrasound scanning
- Abdominal aortic aneurysm (AAA) screening

- Diabetic retinal screening

The practice has two GP partners (both male), one salaried GP (female), one specialist practitioner (female), one practice nurse manager (female), one practice nurse (female) and two health care assistants (both female). Clinical staff are supported by a practice manager and an administration/reception team which includes an apprentice.

The practice offers a variety of appointment options, these being:

- Pre-bookable appointments with a GP or nurse available up to four weeks in advance
- Open access appointments on a Monday 8am to 10am when patients can call the surgery and receive an appointment that day
- Other on the day/urgent/emergency appointments
- Home visits and consultations
- Telephone appointments when the clinician will call back the patient and carry out a consultation over the telephone

Appointments could be made in person, via the telephone or online.

The Castleford Medical Practice is open:

Monday 8am to 6.30pm

Tuesday 8am to 6.30pm

Wednesday 8am to 8pm

Thursday 8am to 6.30pm

Friday 8am to 6.30pm

Out of hours care is provided by GP Care Wakefield and is accessed via the practice telephone number or patients can contact NHS 111.

The last inspection rating was clearly displayed in the practice waiting room and on the practice website.

Good

Are services safe?

We rated the practice as Good for providing safe services.

Safety systems and processes

The practice had some 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. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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, harassment, discrimination and breaches of their dignity and respect. We saw that monthly meetings were held to discuss safeguarding issues.
- The practice generally carried out appropriate staff checks at the time of recruitment and on an ongoing basis. We found that the practice had not carried out checks to assess the full immunity status of staff. We were told by the practice when this was pointed out that they would start this process immediately, and we have received evidence after the inspection that checks on staff immunity are in hand.
- There was an effective system to manage infection prevention and control.
- The practice had some arrangements in place to ensure that facilities and equipment were safe and in good working order. However from evidence seen on the day it would appear that some portable appliances had not been electrically tested since October 2014. Since the inspection we have received evidence that the practice has booked for testing to be carried out by the end of April 2018. It was also noted that in areas the fabric of the building was deteriorating. For example there were areas of crazed tiling and exposed high level woodwork in skylights. The practice was aware of these issues and via NHS Property Services kept such issues under review and control. There were long-term plans to rebuild the premises.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were 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.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and 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 knew how to identify and manage patients with severe infections including sepsis. Sepsis information was clearly displayed in the treatment rooms and in reception.
- 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. There was a documented approach to managing test results.
- 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 generally reliable systems for appropriate and safe handling of medicines, however whilst there was a system in place to handle and action medicines alerts assurance was not fully in place to ensure that all alerts had been received by the practice and acted on accordingly. The practice on being informed of this immediately took action on this and put in place measures to ensure that key staff would be informed directly of all alerts issued.

Good

Are services safe?

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, 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 management in line with local and national guidance. We saw that prescribing performance in relation to antibiotic medication was good and was below local and national averages. Over the previous year, when measured against local prescribing targets, the practice had improved their performance from meeting three measures out of ten to meeting eight measures out of ten.
- There were effective practices in place for verifying the identity of patients during remote or online consultations.
- 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.

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 activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

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 took action to improve safety in the practice.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

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.
- The practice utilised e-consultations with specialist doctors in secondary care (e-consultations are a mechanism that enables primary care providers to obtain specialists' inputs into a patient's care treatment without requiring the patient to go to a face-to-face visit). The practice told us they found this reduced the number of direct hospital referrals made and also assisted with the management of more elderly and frail patients with long-term conditions as it made consultations timelier and did not mean patients had to attend hospital.
- 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 were 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 severely frail had a clinical review including a review of medication and a falls assessment. Patients with moderate frailty were clinically assessed from their medical records.
- The practice operated a "One Stop" service for elderly patients. When an elderly patient had had a consultation appointment but required additional tests such as blood tests these were organised and delivered as part of the same visit. This meant the patient did not need to return to have these carried out. Over the past 12 months 783 appointments were carried out as part of this service.
- The practice supported patients in six care homes. Patients in these homes were offered home consultations and staff from these homes could contact the practice via a priority contact telephone number for telephone advice or to request a visit.
- Older patients who had more than one condition received multi-condition reviews which avoided the need for unnecessary journeys and additional appointments.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. In the previous 12 months from a cohort of 70 patients the practice had carried out 38 over 75s health checks.
- The practice followed up on older patients discharged from hospital. Within one week of receipt of a discharge letter the practice sought to carry out a review and ensured that 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.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review, or where necessary more frequent 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. Patients on chronic disease registers had documented care plans in their notes.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, one of the GP partners had received the postgraduate diploma in diabetes. This GP and a secondary care consultant delivered a weekly complex diabetes clinic at a nearby secondary care setting. In addition the practice offered higher level diabetic services in-house which included insulin and GLP-1 initiation (GLP-1 is an injectable medication used to treat diabetes). From data supplied by the practice we

saw a steady yearly rise in insulin and GLP-1 initiations and in the previous 12 months seven patients had been initiated onto insulin within the practice and 15 patients had been initiated onto GLP-1.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity 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 they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- Only 71% of patients with atrial fibrillation were treated with anti-coagulation drug therapy compared to a CCG average of 89% and a national average of 88%. Recent unverified data shared with us by the practice showed that the performance for 2017/18 had improved to 79%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were significantly above the target percentage of 90%. The practice told us that all missed child immunisation appointments were followed up in partnership with local health visitors.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

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

- The practice's uptake for cervical screening was 73%, which was below the 80% coverage target for the national screening programme. However this performance was comparable to the CCG average of 75% and the national average of 72%. The practice told us that they were aware of their current performance and sought to increase levels of screening through raising awareness amongst target patients and via the provision of a late evening clinic which began in the summer of 2017.
- The practices' uptake for breast and bowel cancer screening was generally in line with the local and national averages. We were told the practice actively encouraged patients to participate in these screening programmes.
- 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 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis, was 42% which was significantly below the CCG average of 66% and the national average of 71%. Recent unverified data shared with us by the practice showed that the performance for 2017/18 had improved to 95%.

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; this included those with a learning disability and the frail elderly with complex needs. Such patients had access to longer appointments and specific health checks.
- 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.

Good

Are services effective?

- 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. The practice were able to tell us of a recent experience when they had supported a patient who was potentially at risk.
- 92% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the CCG and national averages of 84%.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was slightly above the CCG average of 92% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was slightly above the CCG average of 92% and the national average of 91%.
- 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, and if diagnosed care plans were developed.
- The practice offered annual health checks to patients with a learning disability.

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. For example, we saw that over the previous two years the practice had carried out six clinical audits, two of which were completed two cycle audits. These audits showed overall compliance with clinical guidelines and standards.

Where appropriate, the practice participated in local and national improvement initiatives. As examples of this the practice had taken part in the Wakefield Vanguard programme and through this had delivered specific focused care on patients who resided in local residential care homes, in addition the practice had participated in a local health inequalities project which targeted hard to reach patients with long-term conditions such as asthma, diabetes and COPD.

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. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Newly appointed staff were given a thorough induction and had a staff mentor appointed to support them through their introduction to the practice.
- 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 deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents.
- 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.

Good

Are services effective?

- 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, for example through social prescribing schemes.
- 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. Patients were able to access advice and support from an in-house smoking cessation service.

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.
- 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 positive about the way staff treat people, many noted the helpful attitude of reception staff and the caring attitude of clinicians.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Patients who had a visual impairment were highlighted on their patient notes and were physically escorted from the waiting area by the clinician rather than relying on the visual call screen.

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. There was a dedicated carer's area in the waiting room with information and signposting support. The practice had identified 118 patients who had caring responsibilities; this was 2% of the practice list.
- Results from the national GP patient survey showed that the practice was consistently rated highly by patients for involving them in their care. For example, 95% of respondents to the survey stated that the last time they saw or spoke to a nurse, they were good or very good at involving them in decisions about their care, compared to a CCG average of 84% and a national average of 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. 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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account wherever possible 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 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 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.

Older people:

- Patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice supported patients in six care homes. Patients in these homes were offered home consultations and staff from these homes could contact the practice via a priority contact telephone number for telephone advice or to request a visit.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with local health and social care professionals to discuss and manage the needs of patients with complex medical issues.
- Due to the high prevalence of smoking in the local population (24%) staff actively promoted stop smoking messages and provided an in-house smoking cessation clinic.

Families, children and young people:

- The practice offered in-house coil fitting and removal and contraceptive implant insertion.
- We were told and saw evidence to support this that younger patients (15-24 years) were actively encouraged to participate in chlamydia (a sexually transmitted infection) testing. Forms and testing kits were available within the practice.
- We saw there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk.
- The practice had a policy to offer all babies and children same day appointments with a GP.
- Baby clinics had been redesigned and gave extended appointments for 30 minutes which enabled baby checks, post-natal checks and first immunisations to be carried out in one session. Since this approach was introduced 160 mothers and babies have attended.
- Specialist sexual health clinics were run from the Health Centre building on Mondays and Tuesdays.
- The practice had been accredited as being young person friendly by a locally recognised organisation. As part of this work the practice helped to distribute a young person's survey asking the views of young people regarding their health needs.
- The practice was a distribution centre for free access contraceptives to young people.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered extended opening hours.
- The practice supported online services such as appointment booking and ordering repeat prescriptions.
- Telephone consultations were available for patients who could not attend the surgery during working hours.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances which included those with a learning disability and the frail elderly with complex needs.
- The waiting room had themed areas for issues such as long-term conditions, dementia and mental health. This made accessing information much easier.
- From April 2015 to March 2016 the practice participated in a project aimed at reducing health inequalities in the Castleford area. It sought to achieve this by the provision of targeted clinical, emotional and care support for hard to reach patients with long term conditions. Actions included longer appointments, proactively following up non-attenders and providing additional home visits. Over the year the practice made 379 contacts with patients, and had used experiences from the project within the practice to redesign and reconfigure services. Learning from this project was still in place within the practice.

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. In addition the practice had been formally recognised as being Dementia Friendly.
- The practice could refer or signpost patients to a nearby mental health support service.

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.

Results from the national GP patient survey showed that the practice was generally rated above local and national averages with regard to access to care and treatment.

Over the previous two years the practice had transformed their telephone access to improve patient experience. The GP who ordinarily dealt with the patient would speak with the patient when they called regarding an ongoing problem rather than be dealt with by the on-call doctor. Patient satisfaction we were informed was high with regard to this as patients usually got to speak with the GP of their choice and continuity of care was improved. The practice had slowly expanded this service and, this now included follow-ups for results, letters and dealing with acute prescriptions.

The practice also held open access clinics every Monday morning. Any patient who called the practice between 8am and 10am was given an appointment that day with the GP or Specialist Practitioner. The practice told us they had seen a positive response from patients and this was corroborated by patients we spoke with on the day. Since open access clinics began appointment availability on Mondays had increased from 7,557 appointments in 2015/16 to 8,749 appointments in 2017/18, which was an increase of 16%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. 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 also from analysis of trends. It acted as a result to improve the quality of care. For example, following a complaint linked to poor staff attitude the practice provided customer care training to improve staff knowledge and support development.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups 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 seeking ways to address them.
- 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. Leaders also sought to support staff competencies and offered career development opportunities.

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, they recognised that they had to work in conjunction with others, including patients to develop services and meet local needs. The practice had a realistic strategy and supporting plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture and aspiration to deliver high-quality sustainable care.

- Staff stated they felt respected, and valued and felt supported by the leadership and management team. They were proud to work in the practice.
- 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 they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. They told us they felt that leaders within the practice were visible and accessible.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. The practice had a strong training and career development ethos and we saw examples were staff had been support to develop roles within the practice. For example, we saw that a member of the reception team was being trained to be a health care assistant and that a practice nurse was being supported to qualify as a non-medical prescriber.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Good

Are services well-led?

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We did though identify some issues in relation to medicines alerts, portable appliance testing and immunity status of staff which needed improvement.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There we some processes in place to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their activities. The practice had a systematic approach to improvement and had put in place a number of actions to improve performance. For example, the practice sought to improve cervical smear performance by the introduction of a number of measures which included the provision of a late evening clinic, taking pro-active measures to raise awareness, making coding improvements and training additional staff to carry out smear tests.
- 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 implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

In general 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.
- However we were not fully assured during the inspection that processes were in place to receive and action all medicines safety alerts, as we saw evidence that not all had been identified. The practice put in place measures to rectify this immediately on being informed of the issue.

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.

Good

Are services well-led?

- 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). The PPG reported that it felt that there was a very positive working relationship with the practice and that the practice took on board its views and any concerns it may have.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

We saw that there were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- 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.

Please refer to the Evidence Tables for further information...