St Mary's Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. We previously carried out an announced comprehensive inspection at St Mary's Surgery in December 2016 and rated the practice as Good overall with requires improvement for the population group people whose circumstances may make them vulnerable. The practice had displayed their ratings in a prominent place within the surgery.

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

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

Older People – 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

We carried out an announced comprehensive inspection at St Mary's Surgery on 13 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had worked to improve the support offered to people with a learning disability. The number of health reviews offered to people with a learning disability had significantly increased.
- The practice was above average for its satisfaction scores on consultations with GPs and nurses. Results from the national GP patient survey also showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than local and national averages.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- There were clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.

Summary of findings

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

- Continue to develop the carers register to further identify patients who are carers and may need support.

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

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people	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

St Mary's Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.**The team included a GP specialist advisor and a practice manager advisor.

Background to St Mary's Surgery

St. Mary's Surgery is situated in Bloxwich, Walsall and provides primary medical services; with a registered patient list size of approximately 2900 patients. The practice is part of NHS Walsall Clinical Commissioning Group (CCG).

The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract ensures practices provide essential services for people with health issues including chronic disease management and end of life care.

The practice is located in a purpose built health and social care centre and shares the facilities with other NHS Services, including five other GP practices. The demographic area served by the practice is ranked as one of the highest deprived areas compared to England as a whole and is ranked as one out of 10, with 10 being the least deprived.

The practice staffing comprises of:

- Two GP partners (both male)
- One salaried GP (female)
- One independent nurse prescriber
- One practice nurse
- One phlebotomist
- One practice manager, and four administration staff who share the responsibilities for reception and administrative tasks

The practice is open between 8am to 6.30pm Mondays, Tuesdays, Wednesdays and Thursdays and on Fridays 8am to 1pm. Extended opening hours are available from 7.30am on Tuesdays and Wednesdays. GP telephone consultations are available from 6.30pm and 7pm on Tuesdays. On the last Wednesday of every month, the surgery is closed at 1pm for staff training.

The practice has opted out of providing out of hours cover for their patients. WALDOC provides the practice out of hour's service. Patients are advised to call NHS 111for medical advice when the surgery is closed.

Additional information about the practice is available on their website:

www.stmarys-surgery.co.uk

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice had safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Records of staff immunisation status were kept up-to-date as per the recommendation of the last report.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns and were able to share examples with us of the action they had taken to help safeguard patients receiving care and treatment.
- The practice had a chaperone policy, and signs were on display to advise patients that they could request a chaperone. Staff had received chaperone training and DBS checks had been undertaken.
- There was an effective system to manage infection prevention and control. There was a designated infection prevention and control (IPC) clinical lead in place.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Line managers had completed staff rotas for their teams.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff had an alert on the computer which all clinical staff knew how to use. The practice had emergency equipment which included automated external defibrillators (AEDs), (which provides an electric shock to stabilise a life threatening heart rhythm) and oxygen with children and adult masks.
- 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.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- Referral letters included all of the necessary information.

Good

Are services safe?

Safe and appropriate 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, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock and had stocked the suggested emergency medicines assessed as needed. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice's management of high risk medicines was effective.
- Practice nurses used Patient Group Directions (PGDs) to administer medicines.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- 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. For example, the practice had reviewed the way it handled the prescriptions of controlled drugs following an incident where one could not be located. The practice had decided that all prescriptions for controlled drugs would be placed in an envelope and a log kept of the prescription serial numbers.
- There was an effective system in place to log, review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety. Following an alert being received, the practice checked if patients were affected by the medicines or equipment involved and took appropriate on going action where required.
- The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

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's daily quantity of Hypnotics per Specific Therapeutic group prescribed was in line with the Clinical Commissioning Group (CCG) and national average. The England averages were broadly 1% (for that therapeutic group) where the practice prescribed these drugs to 1.77% of patients within that therapeutic group.
- The practice was comparable to the CCG and national averages for antibiotic prescribing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice nurse delivered home services for example influenza vaccinations
- 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 their medication.
- 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.
- The practice followed up on older patients discharged from hospital. It 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.

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.
- Data available showed that the practice scored well for their management of long-term conditions. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading in the last 12 months was 140/80 mmHg or less was 82%, which was in line with the CCG average of 80% and the national average of 78%. The practice exception reporting rate of 2% was lower than the CCG average of 6% and the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- The percentage of patients on the diabetes register, whose last measured total cholesterol within the last 12 months was 5 mmol/l or less was 76% which was comparable to the CCG average of 81% and the national average of 80%. However, the practice exception reporting rate of 7% was lower than the CCG average of 10% and national average of 13%.
- The percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 85% compared

Good

Are services effective?

(for example, treatment is effective)

with the CCG average of 81% and the national average of 80%. The practice exception reporting rate of 2% was lower than the CCG average of 10% and the national average of 12%.

- 73% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma control. This was comparable to the CCG average of 77% and the national average of 76%. The practice exception reporting rate of 1% was lower than the CCG average of 3% and the national average of 8%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds were above the target percentage of 90% and the rate for five year olds ranged from 95% to 100%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. A new system had been devised by one of the practice nurses, and discussions had taken place with the linked Health Visitor to seek community follow-up of those who persistently failed to respond in the future.
- A practice nurse provided sexual health clinics.
- A midwife provided antenatal care every week at the practice.

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

- The practice's uptake for cervical screening was 81%, which was the same as the national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data shared with us by the practice showed that 34% of the patients eligible for a NHS health check had received one. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- 68% of eligible females aged 50-70 had attended screening to detect breast cancer .This was the same as the CCG average and comparable to the national average of 70%.
- 56% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was higher than the CCG average of 48% and national average of 54%.
- In order to improve the uptake of patients attending bowel and cervical cancer screening, the practice had identified and trained a dedicated administrator to ensure patients were sent recall letters on a monthly basis for bowel screening. There was also a similar process for non-responders of cervical screening. The practice told us that they planned to include breast screening in this process shortly after the inspection.

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 travellers and those with a learning disability. At our last inspection, the practice was rated as requires improvement for this population group. This was because the practice had only carried out annual reviews on 18% of patients with a learning disability. At this inspection, we found that the practice had worked hard to improve on this figure. The practice had 15 registered patients with a learning disability of which 73% had received an annual review.

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

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was lower than the CCG and the national average of 84%. However, the practice exception reporting rate of 0% was lower than the CCG average of 5% and the national average of 7%.
- 78% 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 below the CCG average of 92% and the national average of 90%.The practice exception reporting rate of 10% was higher than the CCG average of 6% but lower than the national average of 13%. The practice had identified that this figure was

lower than average. Therefore the practice had recently recruited a member of staff with experience in this area who was working to review patients' needs in a holistic way to improve outcomes for patients.

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 88% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was comparable to the national average.
- 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.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had undertaken a number of audits to review practice. For example, the practice reviewed their list of patients who had been newly diagnosed with high blood pressure to ensure that all relevant checks in line with good practice guidelines had been completed.

The most recent published Quality Outcome Framework (QOF) results for 2016/17 showed that the practice achieved 98% of the total number of points available which was the same as the clinical commissioning group (CCG) average and higher than the national average of 97%. The overall exception reporting rate was 6%, which was lower than the CCG average of 8% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice).

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- 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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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 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.

Good

Are services effective?

(for example, treatment is effective)

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.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All but one of the 28 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and thirty three surveys were sent out and 111 were returned. This represented about 4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 99% of patients who responded said the GP gave them enough time, which was higher than the CCG average of 83% and the national average of 86%
- 99% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 94% and the national average of 95%.
- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 82% and the national average of 86%.
- 95% of patients who responded said the nurse was good at listening to them compared with the CCG and the national average of 91%.
- 93% of patients who responded said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw which was the same as the CCG and the national average.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG and the national average of 91%.
- 94% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. One member of staff was able to communicate using sign language.
- 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's computer system alerted GPs if a patient was also a carer. The practice had identified nine patients as carers (0.3% of the practice list). This was lower than the number at the the last inspection. However,the practice recognised that this figure was low and was working on further identifying patients who were carers. The practice had recently employed a newly qualified nurse with

Good

Are services caring?

qualifications in Health and Social Care and a Higher Education Diploma in Social Work with recent hospital experience working in Elderly Care. They were in the process of establishing a personalised, proactive and accessible review process for frail elderly patients with the aim of identifying support needs including any caring responsibilities.

Carers were referred to local services for support. The practice was starting to offer health checks to carers and offered flu vaccinations.

Since the last inspection, the practice had set up a specialist bereavement service. Staff supported patients who were nearing the end of their life. They also provided information in the form of leaflets and signposted patients to services which could support them further. The practice held a register of patients who had died. Bereavement support booklets were given to families with the death certificate. Following the death of a patient, the practice called the families to offer further support.

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

- 91% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 79% and the national average of 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consulting rooms were situated away from the main waiting area.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception was currently open plan. The practice had approached the landlord to enquire about the possibility of applying a screen to the reception desk in order to further promote patient's privacy.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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 of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example online services such as repeat prescription requests, and advanced booking of appointments were available.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, routine telephone consultations could be booked in advance for patients unable to access the practice within normal opening times. Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for patients who had difficulties getting to the practice due to limited local public transport availability.
- Patients identified as needing support had a dedicated point of contact and were signposted to internal and external services as required.

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 the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The nurse had trained as a specialist practitioner and could prescribe a range of medicines within their role as lead for chronic disease management. The nurse had completed the relevant training to carry out initiation of insulin for diabetic patients.
- Longer appointments and home visits were available when needed.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.
- The premises was suitable for children, babies and breastfeeding mothers.

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 results of an internal patient survey showed that there was a greater demand for extended opening before 8.30am. As a result, the practice offered two days of early morning appointments starting at 7.30am. GP telephone consultations after 6.30pm on Tuesday evenings were also available.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The number of patients who had been identified as carers remained low. The practice was working to improve this through the introduction of personalised, proactive and accessible review process for their frail elderly patients.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice has close links with the community mental health team who were based in the building.

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 July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above average when compared to local and national averages. This was supported by observations on the day of inspection and completed CQC comment cards. Three hundred and thirty three surveys were sent out and 111 were returned. This represented about 4% of the practice population. Data showed:

- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 82% of patients who responded said they could get through easily to the practice by phone compared with the CCG and the national averages of 71%.
- 93% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 84%.
- 93% of patients who responded said their last appointment was convenient compared with the CCG average of 78% and the national average of 81%.
- 86% of patients who responded described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 84% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

Listening and learning from concerns and complaints

The practice had systems and processes in place to take complaints and concerns seriously and to respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. The practice had not received any complaints in the last year. Patients told us that they knew how to make a complaint but did not have a cause for concern.

Are services well-led?

Good

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

Our findings

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 had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing 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.

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 aim of the practice was to provide the best possible care to the population that they served. They aimed to offer a service that was effective, holistic and tailored to the individual needs of their patients. The practice was small and friendly. The practice had a realistic strategy and supporting business plans to achieve priorities.
- 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.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, 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

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

Are services well-led?

Good

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

- Practice leaders had established effective policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local 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 taken 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

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 effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice had listened to the views of patients with regards to their preferred availability of appointments. Data showed that patient satisfaction with appointment times was very good as a result.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. For example, the practice was training the pharmacist to help run clinics that would treat patients with high blood pressure.
- 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. For example, the practice worked with other practices within the Clinical Commissiong Group to peer review referrals to secondary care.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.