The Whickham Practice

Inspection report

Whickham Cottage Medical Practice
Rectory Lane, Whickham
Newcastle Upon Tyne
Tyne and Wear
NE16 4PD
Tel: 01914885555
www.whickhampractice.nhs.uk

Date of inspection visit: 08 May to 08 May
Date of publication: 06/07/2018

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

Ratings

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

Overall summary

This practice is rated as Good overall. Previous inspection January 2015 - Good

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Whickham Practice on 8 May 2018 as part of our inspection programme.

At this inspection we found:

- The practice had systems to keep patients safe and safeguarded from abuse.
- 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.
- The practice routinely reviewed the effectiveness and appropriateness of the care they provided. They ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice organised and delivered services to meet patients' needs. They took account of patient needs and preferences.
- Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.
- There was a focus on continuous learning and improvement at all levels of the organisation. The practice proactively used performance information to drive improvement.

We saw areas of outstanding practice:

- The practice was proactive in their support and care of older patients who made up a large proportion of their patient population. This included identifying and supporting frail patients, effective arrangements for social prescribing, good management of long term conditions and comprehensive care planning. As a result they were able to demonstrate a reduction in non-elective admissions to hospital for this group of patients.
- For 2015/16 and 2016/17 (the latest published data available) the practice had attained 100% in the Quality Outcomes Framework (QOF) scheme for the care and treatment of patients with long term conditions. They had developed a personalised approach to ensure patients were involved in care planning activity.

However, there are areas where the provider should improve:

- The provider should retain a centralised record of clinicians safeguarding training so that there is managerial oversight of when updates are due.
- Sustain recent improvement to monitor and record action taken when the temperatures of fridges used to store medicines fall outside of the permitted range.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

Older people	**Outstanding** ☆
People with long-term conditions	**Outstanding** ☆
Families, children and young people	**Outstanding** ☆
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. Also in attendance were a GP specialist advisor and a staff member from our flexible workforce office who observed the inspection.

Background to The Whickham Practice

The Whickham Practice provides care and treatment to approximately 16,078 patients of all ages from Whickham, Swalwell and the surrounding areas. The practice is part of NHS Newcastle Gateshead Clinical Commissioning Group and operates on a General Medical Services (GMS) contract.

The practice provides services from the following address, which we visited during this inspection:

- Whickham Cottage Medical Practice, Rectory Lane, Whickham, Newcastle Upon Tyne,

NE16 4PD

The surgery is located in a part newly built and part Grade 2 listed building. Health visitors, a community podiatrist and children's speech and language services are based in the same building. There is good access and facilities for patients with disabilities and a lift is available for patients who need to visit the first floor. An on-site car park is available which includes dedicated disabled car parking spaces.

Patients can book appointments in person, on-line or by telephone. Opening hours are as follows:

- Monday and Friday – 8am to 6.30pm
- Tuesday to Thursday – 8am to 7.30pm

Patients registered with the service are also able to access pre bookable GP appointments from 8am to 8pm on a weekday and from 9am to 2pm on a weekend at a nearby extended access facility.

The practice is a teaching and training practice and involved in teaching qualified doctors interested in a career in General Practice and the training of medical students.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and GatDoc.

The practice has:

- Seven GP partners (three female and four male)
- Three salaried GPs (two female and one male)
- One advanced nurse practitioner (female)
- Five practice nurses (female)
- Four healthcare assistants/phlebotomists (female)
- 23 non-clinical staff members including a practice manager, assistant practice manager, secretarial manager, secretaries, administrators, receptionists and prescribing support assistants.

The average life expectancy for the male practice population is 80 (CCG average 77 and national average 79) and for the female population 83 (CCG average 82 and national average 83). 27% of the practices' patient population are in the over 65 age group.

At 57%, the percentage of the practice population reported as having a long standing health condition was comparable with the CCG and national averages of 54%. Generally a higher percentage of patients with a long standing health condition can lead to an increased demand for GP services.

At 55% the percentage of the practice population recorded as being in paid work or full time education was lower than the CCG average of 61% and national average of 62%. The practice area is in the eighth most deprived decile. Deprivation levels affecting children and adults were lower than local and national averages.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had systems in place to safeguard children and vulnerable adults from abuse. Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. All staff received up-to-date safeguarding and safety training appropriate to their role. However the training matrix held by the practice did not record all GP safeguarding training activity and GPs held their own training records in relation to this.
- 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.
- Appropriate recruitment processes were in place. The practice had a comprehensive recruitment policy
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

Systems were in place 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. An effective system was in place to monitor appointment demand and convert pre-bookable appointment slots to urgent appointments.
- 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.

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 and comprehensive 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 reliable systems for appropriate and safe handling of medicines.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance.
- The practice had reviewed their antibiotic prescribing and monitored antibiotic and antibacterial prescribing on a monthly basis.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The practice had emergency medicines in place which were easily accessible and all staff knew of their location.
- The practice had policies in place for the management of medicines which needed to be stored in a refrigerator. However, we had some concerns in relation to the process used to record and monitor the temperature of fridges used to store medicines requiring refrigeration. We were not assured that this confirmed appropriation action had been taken when fridge temperatures fell above or below the recommended range (2°c to 8°c).

Good

Are services safe?

The practice immediately addressed this problem by devising a new recording tool and also provided evidence that appropriate action had been taken when the cold chain had been compromised.
- The provider used appropriate legal mechanisms to enable non-prescribers such as nurses and healthcare assistants to administer prescription only medicines (e.g. vaccines).
- The provider had an effective system in place to monitor and track blank prescriptions in accordance with national guidance.

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 managers 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 systems for reviewing and investigating when things went wrong and evidence of learning being shared with staff.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice, and the population groups relating to older people, those with long term conditions and family children and young people as outstanding for providing effective services. The other population groups were rated as good.

(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.
- 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:

- The practice had recognised that a high percentage of their patients were over the age of 65 (27.1% compared to the clinical commissioning group (CCG) average of 16% and national average of 17.2% - the highest in the local CCG area). They had tailored their services to reflect the specific needs of this group of patients. This included effective care planning involving the patients and their carers if appropriate, proactively identifying and supporting frail patients, a comprehensive approach to the care and management of patients with long term conditions, social prescribing and referral to relevant care and support agencies. As a result, their non-elective admission to hospital rate for this group of patients in 2017 was the lowest in the Gateshead CCG area.
- Older patients who were frail or may have been vulnerable received a full assessment of their physical, mental and social needs. The practice worked closely with their attached frailty nurse to ensure patients could be supported in their homes and avoid unnecessary admission to hospital. Detailed care plans included information concerning the patient's base line functions including memory, coordination and confusion to assist other health care professionals such as paramedics or secondary care practitioners. During 2015/16 only eight of the 70 patients on the practice frailty register experienced a non-elective admission to hospital.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice liaised with local pharmacies to ensure that over 340 of their older patients were able to receive weekly dosette boxes containing their medicines. This assisted patients with memory difficulties, helped promote personal safety, supported their carers and improved medicines compliance.

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.
- The practice sent a personalised 'preparing for care planning' letter to patients following their pre-long term condition review with a healthcare assistant. This gave them full details of results of any tests that had been carried out including blood pressure, cholesterol, diabetes screening, kidney function and thyroid function. This enabled patients to prepare for their full review and care planning meeting with a GP or nurse more effectively.
- The practice was proactive in their care and treatment of patients with diabetes. This included those at risk of developing diabetes or gestational diabetes. At the time of our inspection they had 917 patients on their diabetes register. 98% had received an annual flu immunisation and 100% of those newly diagnosed with diabetes during 2017/18 had been referred to a structured diabetes education programme. Health care assistants had undertaken additional training to enable them to provide diet, exercise and smoking cessation advice to this group of patients and carry out diabetic foot checks.

Families, children and young people:

Outstanding ☆

Are services effective?

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice had scored well above the expected standard of 90% for all four childhood immunisation indicators (between 97.8% and 99.1%)
- 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.
- The practice was able to demonstrate that A&E attendance for children aged under 15 registered with practice had reduced from 1,080 in 2016/17 to 898 in 2017/18. The practice partly attributed this to ease of access for same day urgent appointments at the practice for children. For example, a selection of urgent appointments were embargoed for allocation to acutely ill children. If and when these urgent appointment slots had been used the child would be added to the list for triage by the on-call GP and always seen the same day if clinically necessary. Details of this were promoted on the practice website and in the waiting area. In addition, the practice actively promoted the 'Little Orange Book' which gave parents and carers of babies and small children useful advice on childhood ailments and when and where to seek help. The practice had been commended for their promotion of the Little Orange Book by their local CCG in December 2017.
- The practice had effective safeguarding arrangements in place. They had a 100% attainment rate for providing reports for multi-agency child protection conferences and reviews and multi-agency risk assessment conferences.

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

- The practice's uptake for cervical screening was 82.5%, which was above the CCG average of 71% and national average of 72.1%.
- The practice's uptake for breast and bowel cancer screening was above local and national averages.
- They were proactive in ensuring patients receiving prostate cancer monitoring were regularly reviewed, which included home visit monitoring for those not well enough to attend the surgery.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had three members of staff who were trained to deliver smoking cessation advice. 95% of smokers registered with the practice had been offered smoking cessation advice. Of those that attended, 53% had managed to stop smoking. This was above the local target of 45%.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Receptionists ensured they sent review invitation letters in an accessible format to patients with a learning disability. This was followed by a telephone reminder call on the day of the appointment.

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 medicines.
- 84.3% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable with the local CCG average of 85.4% and national average of 83.7%.
- 97.7% 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 above the CCG average of 88.9% and national average of 90.3%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 93.7% of patients

experiencing poor mental health had received discussion and advice about alcohol consumption. This was better than the CCG average of 91.3% and national average of 90.7%.
- 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.
- Patients with a learning disability were offered an annual health check. The practice had employed a specialist nurse with experience of caring for patients with a learning disability on a temporary basis to help them ensure the practice had identified all relevant patients for inclusion in their learning disability register and that they were receptive to the particular needs of this group of patients. For example, longer appointments or home visits if the patient felt more comfortable in their home environment than in the practice. A member of the reception team had been identified as a lead and point of contact for learning disability patients. The practice had a register of 58 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.

- The practice had achieved 100% of the total number of QOF points available for 2016/17, compared to the CCG average of 97.7% and the national average of 95.5%. At 9.3% the practice exception reporting rate was lower than the local average of 10.1% and national average of 9.9%. The practice had attained 100% of the QOF points available to them for the previous two years.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- 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 were receiving specific training.
- 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, coaching and mentoring, clinical supervision and support for revalidation. All staff were given the opportunity of an annual appraisal.
- Systems were in place to support and manage 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. They shared information with, and liaised, with community services, social services, health visitors and community services as necessary.
- 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.

Outstanding ☆

Are services effective?

- 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. For example, the practice had recruited a number of volunteer patient health champions who were instrumental in signposting patients to relevant support groups and wellness events. Members of the group attended the practice on an almost daily basis to assist patients in the waiting room or to chat to patients who may be socially isolated. In addition they had organised a walking group. A choir and bell ringing classes also operated from the practice. Dependent upon their level of involvement some of the health champions had undertaken disclosure and barring service (DBS) checks. All of the health champions had undertaken information governance training and received a copy of the practice information governance pack.
- A health care assistant had also been identified as the practice social prescribing lead and had created folders for each member of the nursing team and the practice health champions containing information about local luncheon clubs, 'knit and knatter' groups, exercise classes, financial support agencies, home care and other support agencies.
- Representations from a national charitable organisation delivered a session from the practice on a weekly basis to provide patients with advice on a range of issues including debt management, legal and consumer matters.
- 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 and tackling obesity campaigns.
- Reception staff were receptive to the particular needs of patients. For example, taking prescriptions to pharmacies for patients who did not use the electronic prescription 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.

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 about the way staff treat people was positive. The practice was able to show us a large folder of thank you cards from patients who had been happy with the care, treatment and compassion they had received.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

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 had received training in sensory awareness and guided patients to consulting rooms when necessary.
- 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 through the inclusion of caring responsibility questions during health checks, long term condition reviews and new patient registration. Signs in the waiting room and information on the practice website also asked patients to let staff know if they were a carer. Carer's were supported appropriately. This included the offer of an annual health check, flu immunisation and signposting to local support services. The practice had identified 843 patients as having caring responsibilities (approximately 5.2% of the practice patient population). This included 17 young carers.

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 and took account of their needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice premises and facilities were appropriate for the services delivered. Access for patients with mobility issues was good.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. GPs carried out palliative care visits and reviewed seriously ill patients after surgery hours when necessary or to ensure visiting family members were able to be present.

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. GPs undertook a weekly visit to patients residing in nursing homes to assess their medical needs.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice was proactive in ensuring older patients received an annual flu immunisation.
- The practice had recognised that they had a high number of older patients who lived alone and may be prone to feelings of social isolation. They had therefore recruited volunteer practice health champions who ran a 'Chatty Champions' service, whereby volunteers would regularly phone elderly patients who lived alone and may be isolated, to provide company and support. Members of the practice health champion group also attended the practice on an almost daily basis to assist patients in using the blood pressure/height/weight machine in reception and obtain health related and support organisation information and sample bottles without having to wait in the queue at reception. They had also been instrumental in setting up a walking group, choir and bell ringing group at the practice.

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.

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.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice proactively promoted the 'Little Orange Book' which provider parents/cares with expert guidance on how to manage health problems in babies and small children. In December 2017 they had received a commendation from their local CCG in relation to this.
- For the convenience of parents with new babies the practice sent appointments for the six week check and full immunisation schedule in one letter. The appointments were arranged so that they did not take place in the early morning and parents were able to request a telephone call to remind them of their appointments nearer the time.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and telephone appointments. Patients registered with

the practice were also able to access pre bookable appointments with a GP at a local extended access care facilities from 8am to 8pm on a Monday to Friday and from 9am to 2pm on a Saturday and Sunday.
- Patients were able to book appointments online or by using a 24 hour automated telephone appointment booking service. This had been installed at the expense of the practice in response to patient demand.
- The practice had encouraged their patients to register for online services. At 42.8% they had the highest attainment rate amongst practices in local CCG area in relation to this.

People whose circumstances make them vulnerable:

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice offered annual health checks for patients with learning disabilities.
- Practice staff were sensitive to the particular needs of patients undergoing gender reassignment. Staff used the patients preferred name and assisted them in changing their name on medical and other records. A gender neutral WC was available.
- Two of the practice GPs with appropriate expertise and qualifications delivered a substance misuse clinic and provided ongoing care and support to dependent patients in conjunction with a substance misuse practitioner.

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.
- All patients on the practice mental health register were offered an annual health check

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. The practice had an effective system in place to manage capacity and demand. Clinical staff worked flexibly and adjusted their working hours to meet demand as and when required. Two of the practice nurses provided an evening clinic for patients unable to attend during the day.
- The nursing team provided a complex dressing service to avoid patients having to be referred and travel to secondary care services.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately.

- 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 acted as a result to improve the quality of care. For example, a patient had complained about a lack of privacy at the reception desk when requesting an urgent appointment. The patient had been uncomfortable about describing their symptoms so their need for an urgent same day appointment could be assessed. As a result the practice had created a sheet with a numbered list of common ailments and symptoms. The patient could look at the sheet and inform the receptionist of the corresponding number(s) rather than have to say in full what their symptoms were.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders 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 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 practice planned their services to meet the needs of the practice population.

Culture

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

- Staff stated they felt respected, supported and valued. There were positive relationships between staff and teams.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent 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. All staff were given the opportunity of an annual appraisal during which training and personal development needs were discussed.
- Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff 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.

Governance arrangements

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

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

Managing risks, issues and performance

There were processes in place for managing risks, issues and performance.

- There were 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. 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 to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

Good

Are services well-led?

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.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice patient participation group met regularly and were involved in writing the practice newsletter, assisting with flu clinics, analysing patient survey information and suggesting areas for improvement within the practice. They had also been instrumental in organising educational events in response to patient demand. This had included events focused on stroke, Alzheimer's and dementia.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

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