Dr Jadhav and Dr Patil

Quality Report

The Martinwells Centre
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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. (Previous inspection January 2015 – Good)

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 living with dementia) - Good

We carried out an announced comprehensive inspection at Dr Jadhav and Dr Patil on 12 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients 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.

We saw one area of outstanding practice:

- In March 2017 the practice linked with seven neighbouring GP practices to establish the proactive care nurse service. Patients with multiple long term conditions, those at risk of hospital admission and patients in care homes who had little confidence in managing their own conditions were referred to the service. Where other services were involved with the patient, they would continue. For example, diabetic specialist nurse or district nursing services. Initially, the patients confidence in managing their own health condition was assessed and again each time their care plan was updated. Following initial assessment

Summary of findings

patients may be referred to other specialities as needed including social prescribing, the complete care and well-being service or receive advice and support about benefits. Ninety-nine patients had been referred to the service and we saw feedback forms stating how it improved their confidence managing their own health conditions.

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

- Risk assess access to a defibrillator on the premises, weekly checks of emergency medicines and consider keeping a stock of Atropine, a medicine to treat slow heart beats, for potential use when contraceptive devices are inserted.

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

Dr Jadhav and Dr Patil

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector and included a GP Specialist Adviser.

Background to Dr Jadhav and Dr Patil

Dr Jadhav and Dr Patil, known locally as the Edlington Practice, is registered with CQC to provide GP services from The Martinwells Centre, Thompson Avenue, Doncaster, DN12 1JD. The practice provides primary medical care services for 4,781 patients under the terms of the national NHS General Medical Services contract. Further information can be found on the practice website www.theedlingtonpractice.nhs.uk.

The catchment area is classed as within the second most deprived areas in England. Income deprivation indices affecting children (28.25%) and older people (21.9%) are significantly higher than the clinical commissioning group (CCG) (25% and 18%) and England (20% and 16%) averages. The age profile of the practice population is broadly similar to other GP practices in the Doncaster area.

There are two GP partners (one male and one female) at the practice who are supported by a locum nurse practitioner, two practice nurses, one healthcare assistant, a practice manager and administrative team. A proactive care nurse also supports patients registered at the practice.

The practice opening hours are:

- 8am until 6pm Monday to Friday.
- 6.30pm to 8pm on Monday evenings.

The practice leaflet and web site include details of surgery and GP appointments times. GP appointments are available from 8am to 5.30pm each weekday and from 6.30pm to 7.30pm on Monday evenings.

Routine and specialist clinics such as long term condition management, family planning and child health clinics are also available. Out of hours care can be accessed via the surgery telephone number or by calling the NHS 111 service.

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 a suite of safety policies including adult and child safeguarding 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.
- There was a system to highlight circumstances which may make a patient vulnerable on the record system.
- 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.
- 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 we spoke with could provide examples of concerns they had reported which had been acted upon.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) checks. (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).
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis and DBS checks.
- There was an effective system to manage infection prevention and control.
- 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. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- Practice staff were suitably trained in emergency procedures. However the practice did not have access to a defibrillator and a risk assessment for the absence of one had not been completed. Emergency medicines were checked monthly rather than weekly as recommended by Resuscitation Council (UK). All medicines we checked were in date. The practice did not keep a stock of Atropine, a medicine to treat a slow heart beat, for use when contraceptive devices were inserted.
- 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.

Safe and appropriate use of medicines

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

Good

Are services safe?

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- On a medicines refrigerator, used as a back up during flu vaccination season, maximum temperature had been recorded over 8 degrees celsius on several occasions. A separate sheet captured when the refrigerator door was open for stocking. Staff contacted the refrigerator manufacturer on the day of inspection to report the issue and seek further guidance.
- 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.
- 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.
- The practice prescribed less antibacterial prescription items (0.88) compared with the CCG average of 1.09 and the national average of 0.98
- The percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones was 2.6% which was lower than the CCG average of 6% and the national average of 8.9%.

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, following an incident where a test requested by the hospital was missed, staff reviewed the incident and implemented a procedure to follow when tests were requested from other care providers.
- There was a system for receiving and acting on safety alerts. 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 services overall except for those whose circumstances may make them vulnerable which we rated outstanding.

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 number of hypnotic medicines prescribed was 0.43 which was lower than the CCG average of 0.67 and the national average of 0.90.
- We saw no evidence of discrimination when making care and treatment decisions.
- In March 2017 the practice linked with seven neighbouring GP practices to establish the proactive care nurse service. Patients with multiple long term conditions, those at risk of hospital admission and patients in care homes who had little confidence in managing their own conditions were referred to the service. Where other services were involved with the patient, they would continue. For example, diabetic specialist nurse or district nursing services. Initially, the patients confidence in managing their own health condition was assessed and again each time their care plan was updated. Following initial assessment patients may be referred to other specialities as needed including social prescribing, the complete care and well-being service or receive advice and support about benefits.
- Practice patients had a comparative attendance at the same day health centre and lower use of the out of hours service compared to other local practices.
- 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:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients 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. Over a 12 month period 291 health checks had been completed
- 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 could refer the patient with the proactive care nurse and work with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given from April to 2015 to March 2016 were lower at 85% to 89% than the target percentage of 90%. Practice staff now recalled their own patients for childhood immunisations and had achieved over 90% for 2016/2017 year.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Twenty-eight patients aged between 18 and 19 had received the vaccine in the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- 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 had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 75%, which was above the 72% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. During the last 12 months 132 health checks had been performed. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which 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 those with a learning disability.
- In March 2017 the practice linked with seven neighbouring GP practices to establish the proactive care nurse service. Patients with multiple long term conditions, those at risk of hospital admission and patients in care homes who had little confidence in managing their own conditions were referred to the service. Where other services were involved with the patient, they would continue. For example, diabetic specialist nurse or district nursing services. Initially, the patients confidence in managing their own health condition was assessed and again each time their care plan was updated. Following initial assessment patients may be referred to other specialities as needed including social prescribing, the complete care and well-being service or receive advice and support about benefits. Feedback from patients to the service was currently being collected. Ninety-nine patients had been referred to the service and of the feedback forms we reviewed all had stated the patients had improved their confidence in managing their own health conditions.

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

- 80% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is just below the CCG average of 83% and the national average of 84%.
- 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.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the CCG average of 91% 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 96% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable above the CCG average of 94% and the national average of 91%.
- Improving access to psychological therapies (IAPT) is a national programme to increase the availability of 'talking therapies' on the NHS. (IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder). An IAPT counsellor held a clinic at the practice once a week.

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 manager circulated a weekly update to staff with visual icons used to demonstrate progress. Staff told us they referred to this to invite patients for relevant reviews and it was easily understood.

The most recent published QOF results were 99.8% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.3% and national

Good

Are services effective?

(for example, treatment is effective)

average of 95.5%. The overall exception reporting rate was 5.5% compared with a national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. For example, staff reviewed and updated clinical protocols during monthly meetings to keep staff involved and engaged with any changes to them. For example, updates to diabetes and high blood pressure protocol templates.
- The practice was actively involved in quality improvement activity. Two recent two cycle audits had been completed. One focused on the patients taking medicines to prevent strokes and heart attacks being prescribed a certain medicine to reduce stomach acid to ensure appropriate medicines were prescribed. Staff performed a monthly search to detect those patients taking a medicine to stop blood clots forming after a heart attack to make sure they did not take the medicine for longer than necessary.

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 and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, 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 through referral to the proactive nurse and support from practice staff.
- 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.
- Staff also referred patients to the social prescribing project based in the same building. They had the option to prescribe non-medical support to patients. This included support for loneliness and social isolation and to provide information regarding housing issues or advice on debt. The practice had referred 273 patients to the scheme in the last 12 months.

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.

Good

Are services effective?

(for example, treatment is effective)

- 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 of the four Care Quality Commission patient comment cards we received and six patients we spoke with were positive about the service experienced. This is 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. 303 surveys were sent out and 100 were returned. This represented about 2% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and above average for nurses. For example:

- 75% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 89% of patients who responded said they had confidence and trust in the last GP they saw; CCG and national average - 95%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 84%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) and national average - 92%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG and national average - 91%.

The practice were aware of the data and lower GP scores and explained a long serving GPs had retired and new GP had joined.

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.
- 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 patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 49 patients as carers (1% of the practice list).

- Staff would refer patients to the in-house social prescribing service to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families had experienced bereavement, their usual GP would contact them to provide advice on how to find a support service or arrange a further meeting if they wished.

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 mostly in line with local and national averages:

- 80% 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%.

Good

Are services caring?

- 72% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 82%.
- 97% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG and national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 86%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting room.

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, appointments with a GP and practice nurse were available on alternate Monday evenings. Patients could register for online services such as repeat prescription requests and to book appointments in advance.
- Some reception staff were trained in Care Navigation to offer the patient an appointment with the right person for the right amount of time and also signpost to other appropriate services if needed. For example, referral to the local pharmacy for advice regarding treating common ailments.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long term conditions and patients approaching the end of life was coordinated with other services.
- Staff accessed an electronic encyclopaedia of healthcare developed by the CCG, designed to give GPs and other clinicians based at local surgeries fast access to a wealth of information when they were seeing patients. It included referral forms to hospital consultants, contact details for local health services, and details of the 'pathways' of care patients follow according to their medical history. Staff told us by using the system it enhanced their knowledge of the local health and care system and enabled appropriate signposting to 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 advanced nurse practitioner also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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 on Monday evenings.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- For those patients known to the proactive care nurse, they could to contact the proactive care nurse directly and leave a message for a telephone call back. This supported the provision of advice and support when the patient needed it.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 303 surveys were sent out and 100 were returned. This represented about 2% of the practice population.

- 78% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and the national average of 80%.
- 93% of patients who responded said they could get through easily to the practice by phone; CCG – 65%; national average - 71%.
- 81% 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; CCG - 71%; national average - 76%.
- 71% of patients who responded described their experience of making an appointment as good; CCG - 68%; national average - 73%.

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. Four complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- 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, staff reviewed their communication style with a patient following receipt of a complaint. The review included how a different communication style could have been adopted to make sure it did not happen again.

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 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 to deliver high quality, sustainable care.

- There was a clear vision and a realistic strategy 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.
- 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 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 these were addressed.
- 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.
- 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 an 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.

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. Policies and procedures were continually reviewed to make sure they were upto date and fit for purpose.

Managing risks, issues and performance

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

Are services well-led?

Good

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of 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.
- 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.
- 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. Patients' told us staff welcomed feedback and acted upon it.
- There was an active patient participation group share with the other practice and services in the building.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- Staff knew about improvement methods and had the skills to use them.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.