# The Mandeville Practice

## Inspection report

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

## Ratings

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

# Overall summary

**This practice is rated as Good overall.**

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Mandeville Practice in Aylesbury, Buckinghamshire on 25 October 2018. This inspection was completed following changes in the registration of this practice to a new provider of care and treatment.

At this inspection we found:

- It was evident the practice had gone through a period of transition. Improvements had been made, systems implemented to manage and monitor risks and patient feedback was improving. Staff we spoke with recognised the endeavours of the new leadership team and were keen to be part of the new developments.
- There was a safe track record and staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Services at the practice were tailored to meet the needs of individual patients and were delivered to ensure flexibility, choice and continuity of care. In the first six months (since the new provider started) of the contract, the practice had reviewed the needs of its patient population and tailored services in response to those needs.
- The practice had a visible short term, medium term and long-term strategy and supporting business plans which reflected The Mandeville Practice values. The initial phase and short-term six month strategy was referred to as the 'safety and stability' plan. The six month strategy included a focus on embedding a new model of care, recruitment and clinical safety systems.
- The practice had clear and visible clinical and managerial leadership and supporting governance arrangements. There was a high level of constructive engagement with staff and all staff we spoke with told us they felt they were an integral part of the practice and they felt valued.

We saw an area of outstanding practice:

- Although only six months into the contract the leadership team drove continuous improvement and all staff were accountable for delivering safe change. We saw the practice team was committed to meeting the needs of its population. This was evidenced through specific areas of improvement, themed and targeted services, clinical audits and health promotion. This also included a range of initiatives to meet the different patient groups who accessed the practice.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

**Please refer to the detailed report and the evidence tables for further information.**

## Population group ratings

| | |
|---|---|
| **Older people** | Good |
| **People with long-term conditions** | Good |
| **Families, children and young people** | Good |
| **Working age people (including those recently retired and students)** | Good |
| **People whose circumstances may make them vulnerable** | Good |
| **People experiencing poor mental health (including people with dementia)** | Good |

## Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector; the team included a GP specialist adviser and a Nurse specialist adviser.

## Background to The Mandeville Practice

The Mandeville Practice is a GP practice located in Aylesbury in Buckinghamshire and provides general medical services to approximately 15,200 registered patients. The practice is one of the practices within Buckinghamshire Clinical Commissioning Group (CCG).

The practice has been through a challenging three years with three changes in provider and a number of GPs, managers and staff leaving, which had caused instability in the practice. Primary Care Management Solutions Limited took over the contract following a procurement exercise led by the CCG in April 2018.

Clinical services are provided from:

- The Mandeville Practice, Hannon Road, Aylesbury Buckinghamshire HP21 8TR

The practice website is:

- www.mandevillesurgery.co.uk

According to national data there is minimal deprivation in Buckinghamshire; however, the practice is located within a pocket of high deprivation. People living in more deprived areas tend to have greater need for health services and people outside of the country for long periods often has an impact on screening and recall programmes.

The practice has core opening hours from 8am to 6.30pm Monday to Friday to enable patients to contact the practice. Extended hours appointments were also available from 7am each weekday morning. Pre-bookable appointments were also available every Saturday between 8am and 2.30pm.

Patients at the practice could access improved access appointments at primary care access hubs across Buckinghamshire. These improved access appointments were booked via the patients registered practice and offered a variety of appointments including up until 8pm Monday to Friday, selected hours on Saturdays and 9am until 1pm on Sunday and Bank Holidays.

The practice also provides primary care GP services for a local care home (35 patients) within the local area.

The practice comprises of eight GPs (five females, three male), a Physician Associate, a paramedic and two clinical pharmacists. The all-female nursing team consists of two advanced nurse practitioners, two specialist nurses, four practice nurses (one of which is also a social worker) and three health care assistants with a mix of skills and experience.

An assistant manager, reception manager and a team of reception and administrative staff undertake the day to day management and running of the practice. There was

a visible daily onsite management team from Primary Care Management Solutions Limited who oversaw the changes in the practice. This team included a range of staff including clinical staff and the Chief Executive Officer who was also the Registered Manager.

Out of hours care is accessed by contacting NHS 111.

The practice is registered by the Care Quality Commission (CQC) to carry out the following regulated activities: Maternity and midwifery services, Family planning, Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures.

The practice has previously been inspected by CQC on a number of occasions. The most recent occasion was in January 2018, when the practice was managed by a different provider. At the January 2018 inspection, the practice was rated inadequate overall and remained in special measures following an earlier inspection with the previous provider in July 2017.

Good

# Are services safe?

**We rated the practice as good for providing safe services.**

**Safety systems and processes**

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. Several members of staff had additional and enhanced safeguarding training, for example, one of the recently recruited nurses was also a registered social worker. They told us this was beneficial as they could closely consider the impact of safeguarding, social or psychological problems, such as family issues or job stress, when providing patient care. All staff we spoke with knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. We saw the new provider had reviewed the recruitment process and correspondence for the members of staff that transferred from the previous provider. This review led to risk assessments completed until assurance was received that the staff had the correct background checks.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

**Risks to patients**

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The model of care introduced in April 2018 increased the clinical skill mix both in role and numbers to meet patient's needs.
- 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. The paramedic who had joined the practice team had provided bespoke medical emergency training to all staff including cardio pulmonary resuscitation (CPR) training.
- 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.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

**Appropriate and safe use of medicines**

The systems and processes which managed medicines including prescribing had a comprehensive review by the medicines management lead. This review was conducted by the lead pharmacist with the view to provide a person-centred approach to safe and effective medicines use, thus ensuring patients obtained the best possible outcomes from their medicines.

Good

# Are services safe?

This review had led to the recruitment of two clinical pharmacists and a full review of the medicines for residents in a local care home which received GP services from the practice.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. This included a risk assessment of the emergency medicines held onsite.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed previous and live antibiotic prescribing data and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

**Track record on safety**

The practice had systems to manage safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There was an in-house risk stratification tool which measured and coded risks and incidents. This tool was incorporated into the system used 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. This included, where applicable, a review of themes from the period before the current provider was managing the practice.
- The practice acted on and learned from local, national and external safety events as well as patient and medicine safety alerts.

**Please refer to the evidence tables for further information.**

Good

# Are services effective?

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

**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.
- The practice website provided patients with access to a range of information aimed at assessing lifestyle and health practices, such as alcohol consumption and physical exercise. This enabled the practice to provide additional support or advice if indicated.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice ensured patients had time and support in managing their conditions by referring to the in-house specialists and designated teams. We saw ongoing medication reviews by the in-house medicine team. These reviews reviewed the concurrent use of multiple medications by patients including the patients in the care home which accessed GP services from the practice. We also saw the development of a vulnerable patient team to improve services for vulnerable groups. We were told that this work had helped many patients in a variety of ways.

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 their medicines.
- The practice paramedic followed up on older patients post discharge from hospital and following use of NHS111 or the out of hours GP service. This follow up included a review of care plans and prescriptions 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:

- The number of patients registered at the practice with a long-standing health condition was higher than local and national averages. This had resulted in an increased focus on several long-term conditions including asthma, chronic obstructive pulmonary disease (COPD), atrial fibrillation, diabetes and hypertension.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. The respiratory lead GP, nurse practitioner and a clinical pharmacist had created bespoke templates for the management of asthma and COPD.
- For patients with the most complex needs, designated teams worked with other health and care professionals to deliver a coordinated package of care.
- Designated staff who were responsible for reviews of patients with long term conditions had received specific training. For example, there was a designated diabetes team which included two practice nurses, a clinical pharmacist and two health care assistants. The practice had appointed a Diabetes Specialist Nurse (DSN) to support patients with complex diabetic needs. The DSN also provided educational sessions each month. The most recent of which was a session on initiating GLP. (GLP is a form of treatment used in diabetes management).

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above. We were provided with additional data during the inspection which indicated this target was being exceeded.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Good

# Are services 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 support in accordance with best practice guidance. The practice was a breast feeding friendly practice and hosted a regular baby clinic and shared ante-natal, post-natal and child development checks with the health visitors and midwives.

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

- The practice was aware of historic low uptake figures for national cancer screening programmes. The practice was aware of this and implemented a designated cancer screening action plan which aligned to the wider health promotion ethos within the practice.
- The health promotion ethos interlinked with NHS health checks. 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 systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

People whose circumstances make them vulnerable:

- There was a dedicated team who focused on patients living in vulnerable circumstances. This team managed the care of treatment for patients on the vulnerable patient register. The register included patients with a known disability, addiction problems, impaired capacity, homeless people, and those with a learning disability.
- There were 96 patients on the Learning Disabilities register. The practice had started a programme which invited all 96 for an annual health check.
- The Mandeville Practice was the nominated GP practice within the clinical commission group for Gender Dysphoria patients. Staff worked together to understand and meet the range and complexity of individual needs and circumstances.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

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

- The practice assessed and monitored the physical health of people with 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. We saw clinical audit activity which reviewed face to face health checks for patients with severe mental health problems.
- There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had case management arrangements in place to help them to remain safe.
- 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 carried out quality improvement activity including clinical audits and other exercises to review the effectiveness and appropriateness of the care provided. The practice had reviewed the local health priorities and were aware of several clinical areas which required improvement and strengthening. The practice had commenced clinical audits which aligned to the clinical areas which needed improvement. For example, an asthma and respiratory audit, a hypertension (high blood pressure) audit, a prescribing audit used in the care of mental health conditions and a disease-modifying anti-rheumatic drug (DMARD) monitoring audit.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, the national diabetes '8 care process' audit.

Following the commencement of the contract in April 2018, we saw management team had identified the need to review and improve further peripheral processes and procedures used to deliver care and treatment. For example:

- Implemented stronger governance arrangements to manage workflow including scanning, pathology, test results and referral correspondence.

Good

# Are services effective?

**Effective staffing**

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. The designated GP who ran the Gender Dysphoria clinic attended regular training which included training on hormone therapy.
- 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 leadership team recognised this was integral to ensure high-quality care and had appointed an Educational Lead within the practice.
- The practice provided staff with ongoing support. There was an induction and probation programme for new staff. This included one to one meetings, coaching and mentoring, clinical supervision and revalidation.
- At the start of the contract in April 2018 all staff members who transferred from the previous provider received a welcome pack and welcome letter. Staff who transferred all had a one to one meeting including a training needs analysis to identify training, learning and development needs. The practice had introducing a programme of appraisals and an appraisal schedule with a view to complete appraisals for all members of staff before April 2019.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating care and treatment**

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. We spoke to the care home which accessed services from the practice. They praised the coordinated care between the practice and the home, specifically the designated GP, paramedic, over 75's nurse and clinical pharmacist. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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**

The practice was consistent and proactive in helping patients to live healthier lives. Staff told us and we saw evidence of a targeted and proactive approach to health promotion and prevention of ill health, this included education sessions for practice staff and community talks in the local Healthy Living Centre. One initiative we saw was the specialist respiratory GP activated the mobile messaging service to all patients who had signed up to mobile messages and had respiratory conditions. This service provided advice on breathing concerns during the heatwave and subsequent dust storm in Summer 2018, an audit was ongoing to determine the impact of this message. This message and campaign also acted as a reminder to invite patients for an asthma review and to check they had sufficient inhalers.

Good

# 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.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice worked with the local Healthy Living Centre and supported local and national priorities and initiatives to improve the population's health, for example, flu vaccination, stop smoking campaigns, increase physical activity and tackling obesity.

**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. Staff were aware of the need to request consent to share records with referrals in line with GDPR principles (General Data Protection Regulation), as well as new guidance regarding consent with SARs (Subject Access Requests).

**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.

- Verbal and written feedback from patients and stakeholders was positive.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The 2018 national GP patient survey results were published in August 2018 following the collection period between January 2018 and March 2018. Therefore, this data was collected prior to the current provider at the practice. The practice was aware of the results and was using these results and other sources of patient feedback to produce an in-house patient survey.
- All the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. Feedback highlighted positive changes made in the practice over the last six months. This was in line with the improving satisfaction results of the NHS Friends and Family Test and other feedback received by the practice.

**Involvement in decisions about care and treatment**

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Additional services including the treatment room used for cervical screening had been relocated to a more private and quiet area of the practice.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this. As the nominated GP practice within the clinical commissioning group for Gender Dysphoria patients. Staff had received awareness training including the use of pronouns and titles specifically for patients whose assigned sex and gender did not match their .

**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**

Services at the practice were tailored to meet the needs of individual people and were delivered to ensure flexibility, choice and continuity of care. In the first six months of the contract, the practice had reviewed the needs of its patient population and tailored services in response to those needs.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. This work was mainly led by the over 75s nurse, practice paramedic with support from the GPs.
- The practice provided GP services to a local care home for older people. There was a designated GP point of contacts for the home (supporting approximately 35 patients). Contact details of the designated GP were shared with the relevant staff, enabling continuity of care and quick access to the right staff at the practice. Following an engagement meeting in April 2018 between the practice and the care home the designated GP started holding weekly visits to the home and the practice paramedic and over 75s nurse also provided appointments on an ad-hoc basis. One of the clinical pharmacists had allocated time to manage prescriptions for the care home and complete medicine reviews. We spoke with a representative from the home; they advised the practice was highly responsive. Regular meetings were held at the care home with the focus of the meetings to support and educate to ensure the most appropriate care pathway was followed to ensure the best outcomes for patients.
- The practice completed a non-user identification and intervention project. This project identified 1,781 patients over 75 who had not accessed the practice in the previous two years. The practice contacted these patients for a review and a well-being check. We saw some patients did not want any further intervention but appreciated the contact. We also saw this project identified a patient who had stopped taking their medicine following the death of their partner. An action plan was agreed between the patient, their family and the practice which included a medicines review, referral to bereavement counselling and additional support services.

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 community nursing team to discuss and manage the needs of patients with complex medical issues. This included close liaison with the diabetes specialist team for Buckinghamshire.
- Additional clinics had been created which aligned to the local health priorities. This included a hypertension clinic which started in September 2018, complex asthma clinics which started in June 2018 and the appointment of a Diabetes Specialist Nurse to support patients manage their diabetes.

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.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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 Saturday appointments. Additional extended hours appointments were available through collaboration with the clinical commissioning group (CCG) and other local practices.

Good

# Are services responsive to people's needs?

- Designated well women clinics had commenced, this included cervical cancer screening appointments every Saturday morning (predominately for patients of working age). This was supported by educational sessions on breast self-examination.
- Telephone appointments were available for patients who were unable to attend during working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode and those known to experience potential barriers when accessing primary care. For example, the practice was the nominated GP practice within the CCG for Gender Dysphoria patients.
- There was an in-house vulnerable care team who supported vulnerable patients, this included ring fenced home visits which included assessments of patient's environment, mobility or medicines needs they may have.
- The practice made referrals to health and social care services as necessary for this patient group. This included the community drug and alcohol team and the Buckinghamshire 'live well, stay well' service.

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

- The practice offered flexible longer appointments for patients with complex mental health needs. On review of these appointments and the high prevalence of patients experiencing poor mental health the practice recently started daily mental health clinics, this included protected time for medicine reviews by practice based clinical pharmacists.
- Patients with mental illness and those living with dementia were discussed and reviewed during safeguarding meetings where appropriate.
- The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care plans were in place for patients with dementia.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

**Timely access to care and treatment**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- 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.

**Listening and learning from concerns and complaints**

The practice took all feedback including complaints, concerns and compliments seriously and responded to them appropriately to improve the quality of care.

- We reviewed the complaints log and saw several complaints were made regarding concerns prior to April 2018. Although the current provider was not able to fully investigate concerns regarding services pre April 2018, we saw they added any themes or patterns into the current action log.
- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

**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.**

However, we saw an area of outstanding practice related to this key question:

- Although only six months into the contract the leadership team drove continuous improvement and all staff were accountable for delivering safe change. We saw the practice team was committed to meeting the needs of its population. This was evidenced through specific areas of improvement, themed and targeted services, clinical audits and health promotion. This also included a range of initiatives to meet the different patient groups who accessed the practice.

**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 local and national challenges within primary care 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 visible short term, medium term and long-term strategy and supporting business plans which reflected The Mandeville Practice values.

- Primary Care Management Solutions Limited took over the contract in April 2018. The initial phase and short-term six month strategy was referred to as the 'safety and stability' plan. The six month strategy included a focus on embedding a new model of care, recruitment and clinical safety systems.
- We saw a proactive and systematic approach to managing safety and patient demand whilst there was an unprecedented amount of change within the practice. All staff we spoke with wanted to work in partnership with the provider and the patients to navigate changes whilst ensuring the best possible care was always available.
- The strategy and plans were live and reactive to changes in services, they were challenging and innovative and regularly monitored.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. Written staff feedback we received highlighted a common focus on improving the quality of care and patient experience.
- The strategy was in line with health and social priorities across the region. For example, the promotion of healthier lives through a consistent, targeted and proactive approach to health promotion and prevention of ill health.

**Culture**

The practice had instigated improvements with a view to commence a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice, proud of the improvements made and were optimistic about the future. Staff also commented the amount of change in the practice had been challenging but understood the reasons for change.
- The practice focused on the needs of patients. There was a whole team commitment to improve the quality of patient care and the experiences 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 safety incidents, complaints and clinical audit findings. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. The staff meeting structure as well as the inclusive culture of the practice supported this.
- There were processes for providing all staff with the development they need. Although the appraisal programme had only just started, staff had received a training needs assessment and career development conversations.
- There was a strong emphasis on the safety and well-being of all staff. Staff who transferred to the current provider acknowledged the welcome and support they had received during the transition period.

Good

# Are services well-led?

- 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, this included positive relations between staff who had transferred from the previous provider and new staff.

**Governance arrangements**

Governance arrangements had been proactively reviewed and reflected best practice.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, the practice had reviewed and implemented new prescribing protocols, policies and procedures, this included comprehensive medicine reviews. Furthermore, we also saw an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.
- Communication across the practice was structured around key scheduled meetings. Regular meetings took place for staff groups including whole staff, clinicians, clinical governance and reception and administration staff meetings. We found that the quality of record keeping within the practice was good, with minutes and records required by regulation for the safety of patients being detailed, maintained, up to date and accurate.

**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 initial phase and short-term six month strategy included tools and systems which monitored and addressed inherited risks. The strategy included key milestones, thresholds, processes and plans to manage current and future performance.
- Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. The management team had oversight of national and local safety alerts, incidents, and complaints.
- Although only just commenced, clinical audit and other quality improvement activity had a positive impact on quality of care and outcomes for patients. The audit programme was designed and themed to reflect and review the specific needs of the population to improve quality.
- The practice had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The practice worked with the CCG and agreed an action plan which included actions required and how the practice would monitor and complete the required actions. This action plan had been shared with Care Quality Commission prior to the inspection during an engagement meeting in June 2018.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

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

Good

# Are services well-led?

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- In April 2018, the practice relaunched the patient participation group (PPG). After advertising the first PPG meeting via text-online and written correspondence the meeting took place in July 2018. The practice team discussed the new model of care that had been introduced and future ongoing projects. Although currently small in numbers, the PPG included a diverse range of members.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice provided GP services to a local care home. In the last six months, there has been a series of meetings between the practice and the care home. These meetings were used to proactive plan and review the service the care home received. We spoke to the care home prior to the inspection, they commented positively on the new arrangements and looked forward to continued good relations with the practice.
- We spoke to the CCG prior to the inspection, they highlighted the positive engagement between the provider, the practice team and the CCG.

**Continuous improvement and innovation**

The leadership team and all staff groups focused on change, continuous learning and wholesale improvement at all levels within the practice. This aligned to the vision and mission statement of the provider.

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

There was a clear proactive approach to seeking and embedding the provision of new strategies in the delivery of care and treatment. The practice team was forward thinking and proud to be initiators of many pilot schemes to improve outcomes for patients in the area. This included a number of innovative schemes that had been implemented or were in the process of development within the practice in order to improve the care for their patients. For example:

- Designated well women clinics including cervical cancer screening appointments every Saturday morning.
- Daily ring-fenced appointments to improve outcomes for patients experiencing poor mental health had been launched.
- The practice was the nominated GP practice within the CCG for Gender Dysphoria patients.
- Completion of a non-user identification and intervention project. This project identified 1,781 patients over 75 who had not accessed the practice in the previous two years.
- Recruitment of specialist clinical staff including a recently recruited nurse who also a registered social worker. This was beneficial as they could closely consider the impact of safeguarding, social or psychological problems, such as family issues or job stress, when providing patient care.
- There was a dedicated team who focused on patients living in vulnerable circumstances. This team managed the care of treatment for patients on the vulnerable patient register.

**Please refer to the evidence tables for further information.**