Awburn House Medical Practice

Inspection report

Mottram Moor
Mottram
Hyde
Cheshire
SK14 6LA
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https://www.awburnhouse.co.uk

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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?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall (Previous rating October 2015 Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Awburn House Medical Practice on 5 December 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 had clear systems in place to safeguard children and vulnerable adults from abuse and support vulnerable patients.
- 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. We saw a strong culture of providing person centred care demonstrated by all staff, this was also supported by data seen from patient surveys and comment cards received.
- Patients found the appointment system easy to use and valued the morning open surgery. Feedback from patients in relation to access was very positive for example, the percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018) was 99% compared to the England average of 70%.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw some outstanding features within the practice:

- There was a strong, visible person-centred culture where staff were motivated and inspired to offer care that was kind, respectful and promoted people's dignity and independence. They worked in partnership with patients, carers and other health and social care providers to develop services and we were provided with numerous examples of how the positive attitude towards patients and carers impacted on people.
- The practice funded a physiotherapy and podiatry team to provide services in house and could offer a falls assessment service, pulmonary rehabilitation and treat musculoskeletal injuries. Data provided by the practice showed patients were routinely seen and assessed within two weeks and achieved positive outcomes. Feedback from patients was positive with 100% of patients felt their practitioner had helped them.
- Supporting patients with learning disabilities. This work was led by the practice nurse who not only invited adults in for health checks but had also developed a scheme to invite children and their carers with learning disabilities in for reviews. Initial feedback from patients and their carers was positive as they felt it helped children familiarise themselves with the practice and staff, but also helped staff get to know the needs of patients.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

Background to Awburn House Medical Practice

Awburn House Medical Practice is the registered provider and provides primary care services to its registered list of approximately 7100 patients. They deliver commissioned services under a General Medical Service (GMS) contract and is a member of Tameside and Glossop Clinical Commissioning Group (CCG).

The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Regulated activities (Family planning, Diagnostic and screening procedures, Treatment of disease, disorder or injury and Maternity and midwifery services) are delivered to the patient population from the following address:

Mottram Moor

Mottram

Hyde

Cheshire

SK14 6LA

The practice has a website that contains comprehensive information about what they do to support their patient population and the in-house and online services offered: www.awburnhouse.co.uk

At the time of our inspection there were three GP partners (two male, one female), a salaried GP (female), a practice nurse and a health care assistant. Clinical staff are supported by a practice manager and eight other staff in the reception and administration team.

The age profile of the practice population is broadly in line with the CCG averages, however they have an above average percentage of patients over 65 years old (22%, of which 9% were over 75 and 2% aged 85 years and over) and patients with long term conditions. The practice ethnicity profile showed 97% of patients were White British. Information taken from Public Health England placed the area in which the practice is located as the fifth most deprived (from a possible range of between 1 and 10). In general, people living in more deprived areas tend to have greater need for health services.

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. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- The safeguarding lead monitored the safeguarding/ vulnerable patient register and would highlights patients at the weekly clinical meeting who may not have been seen in the previous three months. Where appropriate following discussion a member of the team would check in with the patient, including home visits. The safeguarding lead also held meetings with the health visitor and school nurses to coordinate care for children and families at risk.
- Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an on-going basis.
- 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 adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for staff including temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted 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 a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

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

Lessons learned and improvements made

The practice learned and improvements were made when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2017/18.

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 on-going 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 utilised a range of evidence based tools and templates to carry out holistic reviews of care and provided personalised care plans where appropriate.
- 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.
- The practice was comparable with other prescribers of antibiotics in line with guidance when compared with the England average.

Older people:

- The practice had a higher than average number of patients registered at the practice who were over 65 years of age (22%, of which 9% were over 75 and 2% aged 85 years and over).
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. Patients identified as severely frail were added to the vulnerable patients register which was overseen by the safeguarding lead and any patients not seen in the previous three months would be discussed as part at clinical meetings and the newly establish neighborhood multidisciplinary meetings.
- Patients aged over 75 were invited for a health check and personalised care plans were in place for vulnerable patients over 75. Alongside the physical and mental health check, the opportunities for social interaction activities were discussed and referrals made where appropriate.
- The practice provided care and treatment to many of the patients living in a local care home. They regularly visited the home to review patients and worked with staff to anticipate care needs. GPs had developed a care plan template which they used when a patient first moved into the home to ensure they had all the relevant information to help them provide person centred care and treatment.
- Multi-disciplinary palliative care meetings took place to co-ordinate and review care and regular meetings were held for older patients with complex needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice had a higher than average percentage of patients living with a long-term condition.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice was aware that for some long-term conditions their prevalence rate was below average. As a result, they initiated some quality improvement work to address this. For example, they used new technology to

assist clinicians screening for all patients over 65 years old for symptoms of Atrial Fibrillation (AF). The practice identified several patients with AF and were able to provide appropriate care and treatment.
- The practice invested in providing an in-house podiatry and physiotherapy service for patients. There had been a positive uptake of the services and patients were seen quickly. Early evaluation of the service showed a positive impact on patients' wellbeing, for example, patients with COPD had been assessed for pulmonary rehabilitation which is an education and exercise programme that helps improve the well-being of people who have chronic and ongoing breathing problems.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above average.
- 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 82%, which was in line with the 80% coverage target for the national screening programme.
- The practices' uptake for breast cancer screening and bowel cancer screening was above 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. 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 homeless people, asylum seekers and refugees, and those with a learning disability. The practice had introduced a register of all vulnerable patients, patients on the register would be reviewed at weekly clinical meetings. Every month if patients had not been in contact with the surgery, the nurse or health care assistant would make contact or provide a home visit to ensure patients were safe.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was comparable with the local and national average.
- The practice nurse monitored the mental health register and highlighted patients who may not have been seen in the previous two months at weekly clinical meetings to identify any concerns and follow up where required.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 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.
- The practice offered annual health checks to patients with a learning disability. This was led by the practice nurse who not only invited adults in for health checks but had also developed a scheme to invite children and their carers with learning disabilities in for reviews. Initial feedback from patients and their carers was positive as they felt it helped children familiarise themselves with the practice and staff. This also helped staff get to know the needs of the patients as a whole.

Good

Are services effective?

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. Where appropriate, clinicians took part in local and national improvement initiatives and regularly attended training and events.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision 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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had 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.
- The practice team worked closely with staff within the nursing/residential home in which they provided care.
- The practice hosted neighbourhood multidisciplinary meetings to coordinate and manage the care of vulnerable/complex patients.

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may need 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 such as Be Well Tameside and the social prescribing schemes. The practice also referred patients to 'Healthy Hattersely" which promoted one to one working to enable people to return to work.
- 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 and tackling obesity.
- The practice initiated an improvement plan to improve cancer screening uptake and had appointed a receptionist as a 'cancer champion'. Their role involved promoting screening and alongside other staff they

were trained to undertake follow up telephone reminders for patients who do not engage with this screening. As a result, the practice noted an increase in the uptake of cancer screening.
- As part of the patient health checks offered to all patients over 40 years of the age the practice added a screen for pre-diabetes.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for caring because

- There was a strong, visible person-centered culture where staff were motivated and inspired to offer care that was kind, respectful and promoted people's dignity and independence. They worked in partnership with patients, carers and other health and social care providers to develop services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion and we saw numerous examples of where staff showed this when supporting patients, demonstrating a strong, visible, person-centred culture and the determination and creativity to overcome obstacles to delivering care, especially to an aging population in a rural area. For example, a home visit was undertaken to a vulnerable patient who had not had contact with the practice or other health and social care professionals. Risks were identified and with consent a package of care was put in place to improve the patient's wellbeing. We also saw many examples where the reception team supported people, such as, raising concerns for members of the public who were not patients and tracking down family or the patient's own GP. They also arranged transport for vulnerable patients to ensure they attended appointments, as well as provided telephone reminders and spending time (sometimes hours) with patients who were distressed or confused until relatives could attend.

Speaking with patients, observing staff, reviewing survey data and comment cards received as part of the inspection we found people who used the service were active partners in their care and staff were fully committed to working with carers, families and other health and social care partners to achieve the best outcomes for people. It was clear patients social and emotional needs were regarded as equally important to their physical needs. This was especially evident for vulnerable patients and those patients at the end of life. Feedback from patients was overwhelmingly positive about the way staff treat people.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice had received the Pride in Practice award from the Lesbian, Gay, Bisexual and Transgender (LGBT) Foundation.
- The practice gave patients timely support and information.
- The practice used savings to fund an in-house podiatry and physiotherapy service for patients as they recognised this was a service which would have a positive impact on patient's well-being and prevent patients having to travel to receive the care needed. The service also enabled them to help elderly patients living at home, stay well by providing fall assessments and working with the social prescribing team.
- The practices GP patient survey results were above local and national averages for questions relating to kindness, respect and compassion.
  - The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018) 100%
  - The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018) 98%
- The practice also commissioned an annual patient satisfaction survey and we noted the following results from the latest survey in November 2018:
  - Respect shown to patients from staff – 95%
  - Warmth of greeting from staff – 93%

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. The practice nurse had also initiated a pilot scheme inviting children and their carers with learning disabilities into the practice for reviews to help familiarise children with the service and environment but also develop relationships to understand the children and family's needs more fully.

- 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.

Outstanding ☆

Are services caring?

- Longer appointments were allocated where required.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were above local and national averages for questions relating to involvement in decisions about care and treatment. For example:
  - The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment was 99% (01/01/2018 to 31/03/2018)

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice and all 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.
- The practice offered an open surgery every morning and telephone consultations with a GP were available which supported patients who were unable to attend the practice.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice funded a physiotherapy and podiatry team to provide services in house and could offer for example a falls assessment service, pulmonary rehabilitation and treat musculoskeletal injuries. Data provided by the practice showed patients were routinely seen and assessed within two weeks and achieved positive outcomes for example,
  - Patients assessed within the physiotherapy service who would normally have been sent for scans were able to be diagnosed and begin treatment plan onsite without.
  - Patients who had joint injuries who may have previously required pain relief injection were treated and no longer needed treatment
  - Feedback from patients was positive with 100% reporting they felt the practitioners
- The practice offered online services including ability to view records, order repeat prescriptions, send messages to the surgery and book appointments in advance. Approximately 25% of patients had signed up for this service.

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 GPs and nurses 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.
- The clinical team reviewed all unplanned hospital admissions and attendance at Accident and Emergency to follow up patients where required.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Appointments were available after 4pm should children require urgent on the day appointment and were unable to attend the open surgery.

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. The practice could also book patients appointments with a GP or nurse at the local 7-day extended access service which had clinics at the weekend and in the evening.
- The practice in addition to the open surgery, offered extended hours included early morning and evening appointments.

Good

Are services responsive to people's needs?

- Opportunistic flu vaccinations were offered to patients at different times of day to accommodate carers, workers and school children.

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.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was looking continually looking at ways to make the practice more dementia friendly for example, reducing clutter and obstructions to patient in the building, meeting patients from the waiting room, and plans were in place to renovate the entrance and waiting area.
- Staff participated in regular dementia awareness training and staff were proactive in offering screening for patients where there may be concerns.
- Patients could access same day urgent appointments.

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.
- The practice operated an open surgery daily between 8.30 and 10.30am where were guaranteed to see a GP. This was a very popular service and as result patients may have to wait to be seen. If there was a lengthy wait, patients were offered the opportunity to return home and come back at an approximate time.
- Appointments were available early mornings and evening twice a week and patients could access appointments with a GP, Nurse or HCA at a local seven-day access hub evenings and weekends.
- Waiting times (outside of the open surgery), delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were above with local and national averages for questions relating to access to care and treatment. For example, 100% of patients stated that at their last general practice appointment, their needs were met and 99% responded positively to how easy it was to get through to someone at their GP practice on the phone.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice carried out an annual review of complaints to identify any patterns or trends and these were shared during team meetings.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders demonstrated a strong, visible person-centred approach and inspired all staff to offer care that was kind, respectful and promoted people's dignity and independence.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The 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, person centred, accessible and sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients and clearly understood the challenges faced by many vulnerable groups in accessing primary care and being responsive to older people in care preventing unplanned hospital admissions.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice encouraged and support staff to gain additional skills and qualifications.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

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

Managing risks, issues and performance

Good

Are services well-led?

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice had a well-established patient participation group who told us they felt listened to and valued by the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

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

Please refer to the Evidence Tables for further information.