# The Stubbington Medical Practice

## Quality Report

Park Lane
Fareham
Hampshire
PO14 2JP
Tel: 01329 664231
Website: www.stubbingtonmedical.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 service | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as good overall.** (Previous inspection May 2016 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Stubbington Medical Practice on 8 January 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.
- Care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments. Weekly prescriptions were used for patients who were at risk of over-using medicines. A dedicated member of the prescription team worked with care homes and the clinical commissioning group pharmacist to monitor and reduce polypharmacy, prevent errors and improve efficiency.
- Annual reviews were offered for patients who had a learning disability. A GP acted as a link person for patients with learning disabilities who were living in care homes and would offer home visits if needed.
- Innovation and improvement was a priority among staff and leaders:
- For example the practice had introduced home visits by one of the practice nurses in March 2015 at the

# Summary of findings

time of this inspection this was on two days a week. Additionally the practice had introduced Friday visits to care homes to proactively review patients to avoid unnecessary hospital admissions over the weekends.

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

- Continue with the review of training records to demonstrate what training staff have received.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# The Stubbington Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to The Stubbington Medical Practice

The Stubbington Medical Practice is the provider for the regulated activities, at the only location, which is called is The Stubbington Medical Practice.

The Stubbington Medical Practice has approximately 13,100 patients registered. There are higher numbers of patients aged 50 years and older when compared with the national average. There are fewer patients than the national average who are aged 44 years old and under. The practice provides the medical care for approximately 200 patients who live in care homes. The practice population has few ethnic minorities and is mostly White British, in one of the least deprived parts of the country.

The practice is registered with the Care Quality Commission to provide the following regulated activities:

- Surgical procedures;
- Treatment of disease, disorder or injury;
- Family planning;
- Maternity and midwifery services;
- Diagnostic and screening procedures.

There is one location for the provider The Stubbington Medical Practice. We inspected this location:

The Stubbington Medical Practice

Park Lane

Fareham

Hampshire

PO14 2JP

Practice website: www.stubbingtonmedical.co.uk

Good

# Are services safe?

## Our findings

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

**Safety systems and processes**

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The safeguarding lead for the practice attended relevant updates and shared these with staff. The practice provided reports for safeguarding meetings when they were not able to attend.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. However, records for training were incomplete to demonstrate this. For example, one GP was recorded on the practice's training matrix as having received training at level 2 on children's safeguarding. Their personnel file had evidence that this had been completed at level 3, in line with best practice. The practice was aware of this and was working with staff to collate accurate training records.
- Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

**Information to deliver safe care and treatment**

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

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

**Safe and appropriate use of medicines**

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

Good

# Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use. Weekly prescriptions were used for patients who were at risk of over-using medicines. A dedicated member of the prescription team worked with care homes and the clinical commissioning group pharmacist to monitor and reduce polypharmacy, prevent errors and improve efficiency.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

**Track record on safety**

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. They used the Safe Practice Framework to audit safety and identify areas for improvement. The Audit covered areas such as medicines management; infection control; and reporting of incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The practice used a reporting system which enabled them to share information effectively with the clinical commissioning group (CCG). The systems allowed the practice to produce reports to identify themes and trends. However, during the inspection they found out that the permissions to carry this out had not been updated by the CCG. This issue was being resolved.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice shared lessons learned, identified themes and took action to improve safety in the practice. Such as when a patient with the same name as another patient was contacted for a telephone appointment in error. The practice reviewed their procedures and added an alert to patients' records if there were other patients with the same name. This enabled the clinician to also check the date of birth to ensure the correct patient was contacted.
- The practice was in the process of identifying a lead clinician to manage and monitor significant events and ensure learning was appropriately shared with all relevant staff.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

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

**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' 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 used technology and equipment to improve treatment and to support patients' independence:

- Patients were encouraged to use electronic prescriptions services so that prescriptions could be sent to a local pharmacy directly.
- Community services, such as the district nurses, were able to access specific areas of patients' records to assist with their care and treatment.
- On line eConsult was available to all patients for routine queries which did not need to have a physical examination.
- A system was in place to enable diabetic patients to send in their blood sugar level readings to clinicians for review.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

**Older people**

This population group was rated good because:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medicines.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

**People with long-term conditions:**

This population group was rated good because:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. There was a system in place for long term condition reviews, which included ensuring relevant blood tests had been taken and results received prior to the appointment. 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.

**Families, children and young people:**

This population group was rated good because:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice worked with health visitors, school nurses and social workers when needed if children were deemed to be at risk of harm. A confidential database of known vulnerable families was maintained.
- Patients were signposted when needed to a family liaison worker covering the local schools, and self-referral to Children and Adolescent Mental Health services and young people's local counselling services.

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

This population group was rated good because:

- The practice's uptake for cervical screening was 78%, which was in line with the 83% coverage target for the national screening programme.

Good

# Are services effective?

## (for example, treatment is effective)

- 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.
- The practice offered minor surgery, such as joint injections and removal of skin lesions. GPs worked with local dermatologists who provided advice when needed.

**People whose circumstances make them vulnerable:**

This population group was rated good because:

- There was a system for highlighting and read coding vulnerable people especially children, from any incoming mail or reports. In addition alerts were placed on records to identity vulnerable patients and their families. Vulnerable patients were also identified when they registered with the practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Annual reviews were offered for patients who had a learning disability. A GP acted as a link person for patients with learning disabilities who were living in care homes and would offer home visits if needed.

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

This population group was rated good because:

- Patients with complex mental health needs were identified on registration and flagged to the GP they were registered with for assessment and care and treatment.
- Annual reviews were offered with a nurse and then the GP to develop care plans and monitor treatment. There was a recall system in place to encourage attendance.
- Patients were told about self-referral to counselling services and local support agencies. This information was also available from reception, clinicians and the practice website.< >
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 97%; national 91%)

**Monitoring care and treatment**

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. A range of audits had been carried out, for example, for joint injections to monitor for infection rates post procedure and the effectiveness of treatment provided. Where appropriate, clinicians took part in local and national improvement initiatives. The practice worked with the clinical commissioning group's pharmacist to audit use of antibiotics to ensure these were necessary and relevant for treating infections. Arrangements were in place to monitor high risks medicines and regular searches were undertaken to ensure blood tests had been taken at appropriate intervals.

The most recent published Quality and Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 96%. The overall clinical exception reporting rate was 12% compared with a clinical commissioning group average of 11% and a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

**Effective staffing**

Good

# Are services effective?

## (for example, treatment is effective)

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

- The practice had introduced home visits by one of the practice nurses in March 2015, wholly funded by the practice. This initially consisted of one day a week where a nurse would carry out home visits on behalf of a GP. At the time of this inspection this had increased to two days a week, with another day being used to visit patients living in care homes. The nurse followed a protocol and a meeting was held with a GP following all the visits. The nurse was also able to contact GPs during whilst undertaking a home visit if they had concerns about a patient. The nurse carried out an average of six visits per day.
- The practice provided us with figures to demonstrate how this had impacted on patient care and effective use of GP time. The first audit in April 2015, after two months, showed that initially each GP was undertaking an average of two visits per day, with up to three on a Monday. The nurse took on some of the request for home visits on Mondays and during the two months only one visit by the nurse needed GP input at the time of the visit. The audit was repeated in January 2016 and January 2017.In January 2016 visits were carried out on Mondays and Thursdays. The average number of visits per GP on these days had dropped from just over 2.5 day to just over 1.5 visits on Mondays and to just below 1 on Thursdays.
- When this was re-audited in January 2017, the average visits remained the same. The practice had introduced Friday visits to care homes to proactively review patients to avoid unnecessary hospital admissions over the weekends. We were provided with examples of requests for home visits from care homes and areas needing attention included patients with chesty coughs who could possibly benefit from a course of antibiotics.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills and qualifications. The practice had identified that records of training could be improved and were working on this, to ensure training undertaken by staff had been recorded correctly. Staff were encouraged and given opportunities to develop. For example, staff had received training on the Equality Act and the Mental Capacity Act 2005.
- The practice provided staff with ongoing support. This included an induction process, 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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. Relevant information about vulnerable families was shared in clinical meetings with health visitors and midwives.
- 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 identified patients who may be in need of extra support and directed them to relevant services. This included patients receiving end of life care, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. The practice loaned out blood pressure monitors and glucose monitors to enable patients to check their condition at home and provide the clinicians with results for review.

Good

# Are services effective?

## (for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- In-house weight management clinics, and exercise and slimming on referral were offered by the practice.
- Regular educational events including talks by secondary care consultants were organised.
- Older patients who were housebound were visited at home by senior nurses who provided immunisations.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

**Consent to care and treatment**

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

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

Good

# Are services caring?

## Our findings

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

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 16 patient Care Quality Commission Cards. All of which were positive about the services experienced. A total of 14 of the 16 cards emphasised staff being polite, helpful, caring and considerate and mentioned names of staff. The only comments reflecting any concerns were around appointment availability and waiting times once at the practice. The practice was addressing these concerns on a daily basis to improve patient experience. For example, by publicising more widely the types of appointments available and reminding staff to inform patients when a GP was overrunning on appointment times. Comments reflected results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 222 surveys were sent out and 128 were returned. This represented about 1% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 92% of patients who responded said the GP gave them enough time; CCG - 86%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 91% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 84%; national average - 86%.
- 90% of patients who responded said the nurse was good at listening to them; (CCG) - 91%; national average - 92%.
- 90% of patients who responded said the nurse gave them enough time; CCG - 92%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 89% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG -90 %; national average -91 %.
- 86% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 87%.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. There was also information on local training courses that were run for people whose first language was not English.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice asked patients who were registering with them if they were a carer. Information for carers was

Good

# Are services caring?

also displayed in the waiting rooms. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 154 patients as carers (1% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families had experienced bereavement, their usual GP would usually contact them. Families were offered a patient consultation at a flexible time and location to meet the family's needs and/or advice on how to find a support service.

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

- 94% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 87% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 89%; national average - 90%.
- 86% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 84%; national average - 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, good for providing responsive services.**

**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- The practice had re-arranged the reception area to make it more accessible for patients and wheelchair friendly. A wheelchair was available for loan on site to transport patients into and around the practice if needed. There was also a hearing loop in place.
- The facilities and premises were adequate for the services delivered and the practice were actively looking for solutions to improve space available or potentially to relocate to more suitable premises.
- The practice made reasonable adjustments when patients found it hard to access services. For example, clinicians normally working on the first floor would move to a consulting room on the ground floor if a patient required this.
- The practice had good links with local pharmacies to provide compliance aids, such as medicines dispensers; there are usually two types of a nomad where the various pills are kept for later consumption at the right time and day in small individual boxes; and a blister pack where the pills are sealed in the appropriate compartments in days and times. This enabled safe medicines administration. The pharmacy would also liaise with housebound patients about medicines delivery services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

**Older people:**

This population group was rated good because:

- 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 worked closely with community care teams and district nurses, who were able to access GPs directly for telephone advice and to request home visits for older patients with complex needs or who were acutely unwell.
- If needed older patients who were housebound were visited daily by a GP or nurse daily to monitor their condition.
- Patients living in care homes had regular visits made by a GP. A nurse from the practice visited each individual care home on a set day of the week to provide care and treatment with the aim to reduce unnecessary hospital admissions.
- Vulnerable older patients had alerts on notes which were initiated by either clinicians or receptionists, to remind them about appointments, or notify others that they were visually or hearing impaired or had another disability and might need extra consideration, time or space.
- On-site phlebotomy services were available to save older patients needing to travel to the main phlebotomy clinics. Blood could also be taken at the patients home if they were housebound.
- A senior nurse would visit older housebound patients at home to provide immunisations.
- The hospitals Older Peoples Mental Health team carried out twice weekly clinics from the practice for patients who had difficulties travelling.

People with long-term conditions:

This population group was rated good because:

- 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.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- These patients had a named GP who was usually able to provide telephone advice within 1 to 2 days of a request being made, to promote continuity of care and avoid unnecessary treatments or referrals. Telephone consultations were offered to patients for medicine reviews of straightforward long term conditions, which were more convenient for the patient.
- Senior nurses from the practice carried out home visits to review and monitor patients with long term conditions. Services provided were chronic obstructive pulmonary disease reviews, (a condition which results in shortness of breath) ; cardio vascular disease review (heart conditions); and asthma reviews including spirometry (lung capacity tests) at home.
- The community diabetes team carried out clinics at the practice and were available for telephone or email advice when needed.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

This population group was rated good because:

- There was a flexible appointment system to include after school hours and weekends.
- The practice had a priority service for unwell children aged under 2, whose parents or guardians could always book an urgent same day appointment with a GP directly via reception.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Reserved extended slots for postnatal appointments were available.
- The premises had baby changing facilities, a private breastfeeding space if required, and buggy parking area at entrance.
- Regular meetings were held with health visitors, school / family liaison workers, and midwives.
- Contraception and family planning services were provided by a lead nurse and a lead GP.
- 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.

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

This population group was rated good because:

- The practice offered a flexible appointment system which included early mornings, evenings and weekends, with access to GP, practice nurses and health care support workers in these appointments.
- A senior nurse triage service was available every day and covered areas such as urinary tract infections and back pain.
- Telephone consultations with GPs were also available if appropriate.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

**People whose circumstances make them vulnerable:**

This population group was rated good because:

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

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

This population group was rated good because:

- Same day telephone triage and appointments were available for acute mental health issues.
- Patients were screened opportunistically for dementia and referrals were made to the memory clinic.
- The practice hosted a twice weekly clinic for the local Elderly Mental Health Team to provide a familiar environment for patients and to reduce travelling.
- The practice has obtained accreditation as a "dementia friendly" practice.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- Staff had received training on mental health and the Mental Capacity Act 2005. Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

**Timely access to the service**

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 222 surveys were sent out and 123 were returned. This represented about 1% of the practice population.

- 66% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 61% of patients who responded said they could get through easily to the practice by phone; CCG – 63%; national average - 71%.
- 89% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 84%.
- 85% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 71% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%.

However:

- 41% of patients who responded said they don't normally have to wait too long to be seen; CCG - 56%; national average - 58%.

In response to concerns raised by patients about telephone access the practice had upgraded the telephone system and were monitoring whether this had impacted on patient experiences of contacting the practice. The practice acknowledged that waiting times to be seen were not always effectively communicated to patients. They had reminded staff through meetings and observation of the waiting area to inform patients when a GP was running late.

**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 and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. A total of 18 complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, in December 2017 concerns had been raised about the turnaround time for prescription requests and for some patients there was a delay of over one week for prescriptions to be processed. The practice reviewed its processes and put an action plan in place to achieve a maximum of 72 hours for repeat prescriptions to be processed. This was achieved at the end of December 2017.

# Are services well-led?

Good

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

## Our findings

**We rated the practice, and all of the population groups, as good for providing a well-led service.**

**Leadership capacity and capability**

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

**Culture**

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The three complaints we reviewed contained an apology where needed and evidence of staff reflecting on their behaviours and actions to improve practice when relevant. 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 received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. 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**

# Are services well-led?

Good

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

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 Medicines and Healthcare products Regulatory Agency 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 arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. Patients were encouraged to provide feedback via the national GP survey, family and friends test and through the patient participation group(PPG).
- There was an active patient participation group. This consisted of a committee who met face to face and a virtual group. We spoke with the chair of the committee who explained the role of the PPG and how information was shared by the practice. The group had worked with the practice to publicised areas where improvements could be made. For example, the layout of the reception area was changed following concerns raised with the PPG so that it was more accessible for patients.
- 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 at all levels within the practice. The practice had introduced home visits by a practice nurse to make better use of GP and nurses time. They had also identified that monitoring of significant events and audits needed nominated clinical leads and were in the process of putting this in place. They had also reviewed minutes of meetings and had put into place arrangements to ensure there was more detail of follow up actions and monitoring to demonstrate issues had been dealt with thoroughly.
- 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.