# Ainsdale Medical Centre

## Quality Report

66 Station Rd,
Southport
PR8 3HW
Tel: 01704 575133
Website: www.ainsdale-mc.co.uk

Date of inspection visit: 16 March 2018
Date of publication: 30/04/2018

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

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Key findings

## Contents



## Letter from the Chief Inspector of General Practice

**This practice is rated as Good overall.** (Previous inspection October 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 recently 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 Ainsdale Medical Centre on 16 March 2018.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice was a training practice and supported the training and development of doctors and GPs.
- The practice infection prevention and control systems were effective.
- There were systems in place to reduce risks to patient safety. For example, infection control practices were carried out appropriately and there were regular checks on the environment and on equipment used.The practice had appropriate facilities, including disabled access. It was well equipped to treat patients and meet their needs.

# Summary of findings

- Complaints had been investigated and responded to in a timely manner.
- There was a clear leadership and staff structure and staff understood their roles and responsibilities.
- The provider had a clear vision to provide a safe, good quality service.
- Feedback from patients was used to make improvements to the service.
- There was a focus on continuous learning and improvement.
- Clinicians assessed patients' needs and delivered care in line with current evidence based guidance. The provider routinely reviewed the effectiveness and appropriateness of the care provided.
- Feedback from patients about the care and treatment they received from clinicians was positive.

We saw areas of outstanding practice:

- The practice proactively engaged with the wider health and social care communities to support improvement and innovation. For example, working collaboratively with local health and social care services to reduce social isolation of older patients, patients with dementia and their carers and those patients affected by cancer.
- A GP partner at the practice with a special interest in cardiology had a vision of how to improve the cardiovascular service offered to patients within the CCG area. The GP with the support of his GP partners took this vision to the GP Federation and the CCG and with the support of both organisations was able to set up this new service to benefit patients at every GP Practice across the CCG. This work was undertaken by the practice to provide a more effective and patient centred service. As a result of this work fewer referrals to secondary care have been made and more patients were being effectively treated and monitored by their own GP practices.
- The practice used the computer system to ensure that vulnerable patient registers were refreshed each night to ensure they had the most current information to enable clinical and none clinical staff to provide appropriate support and treatment. This also supported the practices safety netting processes.
- Following issues raised by the district nursing service with regard to the pain management of patients receiving end of life care, one of the GP partners devised an analgesia checklist for district nurses to use to inform and support their clinical decision making. Following a trial period, the checklist has been adopted by the CCG and is now used in all their practices.
- The practice had set up an in house Diabetes Education and Self-Management for On-going and Diagnosed DESMOND group that mirrored the NHS programme to support patients with type 2 diabetes and those patients at developing the condition.

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

- The practice need to ensure all clinicians used consent forms to document patient consent for treatments such as joint injections.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

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

# Ainsdale Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector**.** The team included two GP specialist advisers and a practice manager specialist advisor.

## Background to Ainsdale Medical Centre

Ainsdale Medical Centre is operated by Ainsdale Medical Centre. The practice is situated at 66 Station Rd, Southport PR8 3HW. The website address is **www.ainsdale-mc.co.uk**.

The practice provides a range of primary medical services including examinations, investigations and treatments and a number of clinics such as clinics for patients with diabetes, asthma and hypertension.

The practice is responsible for providing primary care services to approximately 12,538 patients. The practice is based in an area with lower levels of economic deprivation when compared to other practices nationally.

The staff team includes eight general practitioners who are partners and one salaried general practitioner. There are three nurses, two healthcare assistants, a practice manager, a business manager and administration and reception staff. Four GPs are male and five GPs and the nursing team are female.

Good

# Are services safe?

## Our findings

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

**Safety systems and processes**

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

- The practice had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- 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. We reviewed documentation that showed clinicians had acted on concerns and had involved other agencies to ensure vulnerable patients had been safeguarded from further incidents of 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. When needed only clinical staff carried out the role of chaperone.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going 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). We discussed with the practice the issue of how long a DBS check for an independent locum GP would be considered appropriate.
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for locum GPs 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.

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

Good

# Are services safe?

**Safe and appropriate 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, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. We discussed with the practice that they should reviewed the current system in place to monitor uncollected prescriptions to include clinical input for vulnerable patients who have not collected their prescriptions. Following the inspection the practice provided evidence that showed a process had been put in place to ensure clinicians where made aware of vulnerable patients who had not collected their prescriptions.

**Track record on safety**

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example following an incident the practice had reviewed how they monitored and diarised patients who required regular injections of medicines.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

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

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used 'open prescribing net' website to monitor their prescribing against national and CCG guidance and trends. With information gained from this website the practice had undertaken medicines audits to support consistency within clinicians. Following on from this the practice had also carried out detailed medication reviews to support effective patient treatment and to ensure value for money for the NHS.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice had a significant number of older patients (approximately 1800 patients aged over 75, 14.2% and 480 over 85, 3.8% of the patient population).
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice identified issues with the community based Cardio Vascular Service and had been the main driver to redesign the service to improve clinical outcomes for patients and improve access to the service.
- 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 set up an in house Diabetes Education and Self-Management for On-going and Diagnosed DESMOND group that mirrored the NHS programme to support patients with type 2 diabetes and those patients at developing the condition.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 83% compared to the CCG average of 82% and the national average of 79%.
- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy was 93% (CCG average 87%, national average 88%).
- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation was drug therapy 93% (CCG 87%, national average 88%).

Good

# Are services effective?

## (for example, treatment is effective)

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 higher than the national target of 90% with an average uptake of 95%.
- 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 81%, which was in line with the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. 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, travellers and those with a learning disability. The practice used the computer system to refresh the vulnerable patients registers each night to ensure they had the most current information to enable clinical and none clinical staff to provide appropriate support and treatment.

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

- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 97% 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 comparable to the national average.
- We discussed with the practice the need to review the current system in place with regard to how the annual reviews of patients diagnosed with poor mental health were carried out. Following the inspection the practice provided evidence that showed the review had taken place and changes to the system had been made.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 92% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, following issues raised by the district nursing service with regard to the pain management of patients receiving end of life care, one of the GP partners devised an analgesia checklist for district nurses to use to inform and support their clinical decision making. Following a trial period, the checklist was adopted by the CCG to be used in all their practices.

The most recent published QOF results were 99.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall exception reporting rate was 4.5% compared with a national average of 9.6%. (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.)

Good

# Are services effective?

## (for example, treatment is effective)

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 87% compared to the CCG average of 79% and the national average of 78%.
- The percentage of patients who had a review within six months of a cancer diagnosis was 90% (CCG 80%, national average 71%).
- The practice used information about care and treatment to make improvements. For example, the practice identified issues with access to the cardio vascular disease service provided by the CCG in collaboration with the local and community trusts. The practice sought approval from the CCG to review the service. A GP partner who was also the CCG lead for cardio vascular disease carried out the review. The review included an audit of all GP referrals in the CCG area over a specific time period and waiting times to be seen by the service. Following the review the service was redesigned in partnership with the local GP Federation, CCG, local and community trusts to ensure it was community based and patients received effective treatment and timely access to the service. The practice had carried out audits and found the majority of patients were now seen within two weeks for an initial consultation. The audits also identified that fewer patients were being referred to secondary care services as their clinical conditions were being effectively and safely managed by their GP practices. Following the success of the redesign the CCG had commissioned the service for a further twelve month period.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice volunteered following a request form their CCG to be a pilot practice for the NHS initiative known as 'Time for Care' programme. The initiative was designed to help practices release capacity, work together at scale, enable patient self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GPtimeand improving access to services.The practice focused on correspondence coming into the practice and how they could work to ensure correspondence was reviewed in the most effective way and by the most appropriate person. To do this the practice made the decision to carry out a small pilot with two GPs, the practice manager and designated administration staff to ensure systems, processes, training and guidance were in place before the decision was taken to roll out the new system of managing correspondence. The practice reviewed the work that had been carried out and found that 60% of documents coming into the practice were able to be dealt with and filed without the involvement of clinicians. This had resulted in the GPs being able to see more patients. We viewed robust systems and processes that were in place to support staff to review correspondence including detailed guidance with regard to the types of correspondence that must be seen by a clinician.

**Effective staffing**

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- 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.

Good

# Are services effective?

## (for example, treatment is effective)

- 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 carried out audits with regard to patients who had received care and support at the end of their lives.

**Helping patients to live healthier lives**

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

**Consent to care and treatment**

The practice obtained/did not obtain 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.

We discussed with the practice the need to ensure all clinicians used consent forms to document patient consent for treatments such as joint injections.

Good

# Are services caring?

## Our findings

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

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 222 surveys were sent out and 136 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:

- 98% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 88%; national average - 85%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.

**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.
- 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 identified patients who were carers and had a designated member of staff (care navigator) to support and monitor the input the practice offered to carers. Information was available in the waiting area and the computer system prompted clinicians to ask patients if they were carers or had carers supporting them. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 261patients as carers (2% of the practice list).

- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.
- The practice had developed a time sensitive system to place an alert on the computer system of recently deceased patients, their family members or carers to reduce the risk of inappropriate calls and correspondence about the deceased patient or for non-urgent recall appointments for themselves.

Good

# Are services caring?

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 with local and national averages:

- 96% 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 88% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 84%; national average - 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

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

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

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

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests advanced booking of appointments, advice services for common ailments.
- 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 had a lift to support patient access.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Practice staff attended the Older Peoples forum for Ainsdale (monthly) to enable them to understand the issues facing the older people in their community. The practice also used these meetings to network with other stakeholders particularly those in the Voluntary, Community & Faith (VCF) services to enable the practice to more effectively support and signpost patients who may be socially isolated.
- The practice had supported the reception team to attend local luncheon and social clubs for older people living in the Ainsdale area to enable them to more effectively signpost patients to services that may improve their emotional and social wellbeing.
- The practice had supported a local painting for pleasure group and examples of their work were displayed in the waiting area with information about the group and how to contact them.

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 practice had set up links with the local Macmillan Cancer Support Service and actively sent staff to the service in order to gain a better understanding of what the service did and how they would be able to support their patients affected by cancer.

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 16 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- 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:

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice held a register of those patients due to their vulnerability and disability were able to order their repeat prescriptions by telephone.

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.
- Alerts were placed on patient records to enable clinicians to provide appropriate care and support.
- The practice had undertaken training to become dementia friend and dementia champions.
- The practice host the local Alzheimer's Society to carry out monthly information and support surgeries for their patients.

**Timely access to care and treatment**

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

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

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable and better than local and national averages. This was supported by observations on the day of inspection and completed comment cards. 222 surveys were sent out and 136 were returned. This represented about 1% of the practice population.

- 90% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 80%.
- 78% of patients who responded said they could get through easily to the practice by phone; CCG – 64%; national average - 71%.
- 82% 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 - 75%; national average - 75%.
- 94% of patients who responded said their last appointment was convenient; CCG - 94%; national average - 81%.
- 88% of patients who responded described their experience of making an appointment as good; CCG - 73%; national average - 73%.
- 72% of patients who responded said they don't normally have to wait too long to be seen; CCG - 72%; national average - 58%.

The practice also proactively carried out patient surveys to ensure that the services provided met the needs of the patient population. As part of this work the practice engaged with their Patient Participation Group PPG to actively listen to patients' views and opinions with regard to the development of the practice.

**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. Eight 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. Following a complaint the way in which the practice recorded and searched for information about patients who had recently died was changed.

# 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 well-led services.**

**Leadership capacity and capability**

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

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and 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.
- 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 their vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice responded to complaints in a timely manager and offered apologies when appropriate. 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.
- The practice actively engaged with staff to ensure appropriate training and support were provided. 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. 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.

# Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The practice management team had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

**Managing risks, issues and performance**

There were 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. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

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. For example the practice was involved in a pilot within the CCG to use a computer system called GP Team Net this system supported the clinical and corporate governance of the practice.
- 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 worked with both the CCG and local GP federation and carried out projects to support improvement for not only their patients but the wider community.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice produced a patient newsletter every six months to support engagement with patients.

**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 recently agreed to pilot a web based tool to improve information collection, task management and to improve how staff accessed information in one application. This included significant event records, training records, health and safety checks, policies, procedures and guidance. The practice intended to expand the use of this web based tool to cover all non-clinical governance processes and systems.

# Are services well-led?

Good

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

- Staff knew about improvement methods and had the skills to use them. The practice held regular meetings with all groups of staff. Staff spoken with told us they felt able to raise issues and felt listened to and valued.
- 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.