Lowther Medical Centre

Quality Report

1 Castle Meadows
Whitehaven
Cumbria
CA28 7RG
Tel: 01946 692241
Website: www.lowthermedical.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 March 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 at Lowther Medical Centre on 2 November 2017 as part of our inspection programme.

At this inspection we found:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and generally well-managed, although some risk assessments and policies were overdue for review.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

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

- Review risk assessments and policies which are due for renewal and update them as required.
- Make sure documentation for Patient Group Directions and Patient Specific Directions is signed as directed.
- Continue to monitor and improve access to appointments.

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

Lowther 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 a GP specialist adviser and a practice manager adviser.

Background to Lowther Medical Centre

Lowther Medical Centre is based in the centre of Whitehaven, Cumbria, and provides services to patients from one location: 1 Castle Meadows, Whitehaven, Cumbria, CA28 7RG. We visited this address as part of the inspection.

The practice is located in a purpose built building and provides services to patients at ground and first floor levels. They offer on-site parking including disabled parking, accessible WC's and step-free access. A passenger lift is available for patients to use to access the consulting rooms on the first floor. They provide services to approximately 10,000 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has two GP partners plus three salaried GPs (two male, three female). There are also two nurse practitioners (both female), three practice nurses (all female), one healthcare assistant (female), two phlebotomists, a practice manager, a deputy practice manager, a care co-ordinator, a clinical interface manager and 13 full and part-time support staff.

Opening times are 7.30am to 6.30pm Monday to Friday. Telephones are answered from 8am until 6.30pm on these days. Outside of these times, a pre-recorded message directs patients to 999 emergency services, NHS 111 or out-of-hours providers, as appropriate.

Information taken from Public Health England places the area in which the practice is located in the fourth more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly older population than national averages. There are more patients registered with the practice over the age of 65 years than the national average.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Cumbria Health On Call (CHOC).

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 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 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. They 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.
- There were systems for safely managing healthcare waste, and the practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, staff were unable to find the certificate to show that the electrical safety of the practice building had been checked. Since the inspection, the practice has told us that they have arranged for a new electrical survey of the building to be carried out.
- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff, although some of these were due to be updated. For example, we found that the risk assessments and policies relating to the Control of Substances Hazardous to Health (COSHH) were due to be updated in November 2016. However, the practice was able to show that the recently-appointed deputy practice manager was in the process of updating any policies and risk assessments which were past their review date. 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 accessible to all staff. They outlined clearly who to go to for further guidance.

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.

- 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.

- 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.

Good

Are services safe?

Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment), however some of these had been signed by the authoriser in the wrong section. Patient Specific Directions (PSDs) were in place for the healthcare assistant to administer certain vaccines. (PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)

- 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. 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 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, the practice had changed their system for sending tasks from GPs to reception staff after they found some of these were being missed. The new system put safeguards in place to prevent this from happening in the future.
- 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.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group was higher than the local and national average at 1.48 (clinical commissioning group average 1.15, national average 1.01). The practice was aware of this and monitored their performance as part of the clinical commissioning group's Quality Improvement Scheme. Audits we saw which had been completed by the practice to measure antibiotic prescribing showed it had reduced in the past 12 months.

Older people:

- 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 medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- 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:

- 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.
- There were no outliers in data identified in the data pack relating to long-term conditions.

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 in line with the target percentage of 90% or above.
- The practice operated a "sick child" protocol which automatically triggered a triaging system for reception staff to use to assess the severity of an unwell child's condition, ensuring they received appropriate medical attention quickly.

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

- The practice's uptake for cervical screening was 84%, which was above the 80% coverage target for the national screening programme.
- 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 those with a learning disability.

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

Good

Are services effective?

(for example, treatment is effective)

- 98% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This is better than the national average.
- 95% 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 better than the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 96% of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (CCG 93%; national 90%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice was part of the CCG's Quality Improvement Scheme aimed at reducing health inequalities across the county by setting all the practices in the area certain quality targets.

The most recent published Quality Outcome Framework (QOF) results were 98.4% of the total number of points available compared with the clinical commissioning group (CCG) average of 97.7% and national average of 95.3%. The overall exception reporting rate was 12.6% compared with a national average of 9.8%. This had dropped from an exception reporting rate of 14.7% in 2016. (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.)

The practice used information about care and treatment to make improvements. For example, we saw there was a programme of continuous audit to monitor clinical performance against best practice guidelines. One such audit had led to an improvement to the system for sending clinical samples for testing at the local hospital.

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 healthcare assistant was offered training to meet 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.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. These patients were also referred to the practice's care coordinator, who undertook home visits to assess their physical, psychological and social needs. The care coordinator completed a care plan for these patients and referred them to other services as appropriate.
- 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 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, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 14 patient Care Quality Commission comment cards we received were positive about the service experienced, although two also stated they found it hard to make an appointment. 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. 261 surveys were sent out and 110 were returned. This represented about 1% of the practice population. The practice was mostly in line with averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 86%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 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, including in languages other than English, informing patients this service was available.
- 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. They did this by asking patients if they were carers when they joined the practice, while the care coordinator at the practice identified carers of patients on their caseload during visits. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 182 patients as carers (approximately 2% 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 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.

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 mostly in line with local and national averages:

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 91% say the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.

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, as good for providing responsive services across all population groups.

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 facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, there was a nurse practitioner who had been appointed to carry out home visits, and appointments were embargoed in the late afternoon for patients who work or attend school or college.
- 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.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. The practice operated a "sick child" protocol which automatically triggered a triaging system for reception staff to use to assess the severity of an unwell child's condition, ensuring they received appropriate medical attention quickly.
- Appointments were embargoed in the afternoons for students who attended school or college and therefore could not come to the practice during the day.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and after-work appointments which were held for people who needed them.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances, including those with a learning disability.
- A drug and alcohol worker was available to see patients at the practice once every two weeks, and a counsellor was available once a week.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Timely access to the service

We were assured that the practice were taking active steps to improve appointment availability, and that they continued to assess the situation. Although results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly below local and national averages, on the day of inspection we saw that 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 managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

The practice had made a number of changes to the appointment system since the last inspection in March 2016. The walk-in service had been changed from a nurse-led triage system to allow patients to see a GP or nurse practitioner directly. Anyone who arrived at the practice during the walk-in service (8am to 9.45am, at the time of inspection) could take a number and wait to be seen. The practice had moved the time of this service to make more clinicians, and therefore more appointments, available. They were measuring the impact of this with a view to changing the time again. Following an audit by the reception team of phone calls from patients requesting appointments after work, pre-bookable appointments were embargoed in the late afternoon and made available each day for people who worked or who attended school or college. There were also pre-bookable appointments available at 7.30am daily. Some pre-bookable non-urgent appointments were released daily for up to two weeks in advance.

We checked the appointments system at 10.37am on the day of inspection and found that an urgent appointment was available at 11.10am. A non-urgent appointment was available within two weeks. There were also four telephone appointments remaining. We saw that there were appointments embargoed for late afternoon too which could be booked by people who worked or attended school. This was an improvement on what we saw during the inspection in March 2016.

Patients we spoke to on the day of inspection and patients who completed comment cards were mostly positive about the changes made and the impact these had had on their ability to book appointments. Only two of the 14 comment cards received stated that they found it difficult to make an appointment, while three of the cards said that the walk-in appointments were "convenient" and had "made it so much easier to see a doctor".

The practice carried out surveys on patient satisfaction regarding access. The most recent survey of 147 patients found that 65% of those surveyed felt that the open access system had made it easier for them to get an appointment, while only 9% felt it had not.

The responses from the practice's NHS Friends and Family test were mixed regarding appointments, but had improved since the last inspection. From 173 responses between February and October 2017:

- 32% said they found it "not very easy at all" to get an appointment.
- 43% said they found it "slightly" or "moderately" easy.
- 25% said they found it "very" or "totally" easy.

National GP patient survey results were similar to those we saw in March 2016. Of the 261 surveys which were sent out, 110 were returned. This represented about 1% of the practice population. Of those who responded:

- 71% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 84%.
- 41% of patients describe their experience of making an appointment as good compared to the national average of 73%.
- 56% of patients say the last appointment they got was convenient compared to the national average of 81%.
- 69% of patients were satisfied with the practice's opening hours compared to the national average of 76%

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 28% of patients feel they don`t normally have to wait too long to be seen compared to the national average of 58%.
- 38% of patients usually wait 15 minutes or less after their appointment time to be seen compared to the national average of 64%.
- 32% of patients said they could get through easily to the practice by telephone compared to the national average of 71%

Staff we spoke to felt patients wanted to see specific GPs, and this discouraged some patients from wanting to use the walk-in service and they were instead choosing to wait until their preferred GP was available. Patients we spoke to on the day also said they would rather wait to see a specific GP. A patient survey completed recently by the practice asked patients if they had a preferred doctor, and if they would chose to wait longer to see a specific GP; 39% of patients surveyed stated that they did have a preferred GP, but only 28% said they would rather wait longer to see that doctor. However, among the over 65s this figure rose to 49%.

Another measure the practice had taken to improve access was to promote the use of booking online appointments. They felt that this would reduce the demand on the phone lines. They had put information about online services on the walk-in appointment number cards, as well as sending text messages to patients to promote its use. We saw that on the day of inspection 760 patients were registered for online access, while another 125 were in the process of completing the application. This represented a total of 9% of the patient list, up from 450 patients (4.5% of the patient list) in March 2017. However, the recent patient survey the practice completed to review access showed that only 2% of the patients surveyed booked their appointments online at present, and that 69% of patients across all age groups stated they preferred to book appointments by phone.

The practice recognised they still had work to do to ensure that all patients were happy with the appointment system. Plans for the future included increasing the number of phlebotomy appointments to free up nursing appointments, as the practice had found that a number of these had been booked by patients requiring blood samples.

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. Eight complaints were received in the last year. We reviewed these complaints and found that they were 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, the practice amended the wording of a standard letter which was sent to patients following a complaint.

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 provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was a "You Said, We Did" display in the waiting area to inform patients of changes made to the service as a result of their feedback.
- 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.

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.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Some of these policies were due to be reviewed, but the practice was aware of this and in the process of reviewing them.

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. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice had completed a number of patient surveys, as well as staff audits, to review the appointment system and look for improvements.
- There was an active patient participation group.
- 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. For example, the reception team had undertaken an audit of phone calls from patients who were requesting appointments later in the day due to work. This led to appointments being embargoed in the late afternoon for patients who work or attend school.
- Some staff knew about improvement methods and had the skills to use them.

Are services well-led?

Good

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

- 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.