

Belmont & Sherburn Medical Group

Quality Report

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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?	Requires improvement	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection June 2016 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Requires Improvement

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 Belmont & Sherburn Medical Group on 19 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to keep patients safe and safeguarded from abuse.
- 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 they provided. They ensured that care and treatment was delivered according to evidence-based guidelines.
- Quality Outcomes Framework (QOF) for 2016/17 showed the practice had achieved 100% of the points available to them for providing recommended treatments for the most commonly found clinical conditions.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice organised and delivered services to meet patients' needs. They took account of patient needs and preferences.
- Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.
- However, results from the July 2017 annual National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment was

Summary of findings

well below local and national averages. The practice had had carried out extensive work to understand the reasons for this and had made improvements. Various changes to the appointments system had been trialled; there was an ongoing audit and review of clinicians' rotas.

- There was a focus on continuous learning and improvement at all levels of the organisation. The practice proactively used performance information to drive improvement.

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

- Take action to improve medicines management arrangements: ensure that staff know what to do if the medicines refrigerator temperatures are higher than recommended levels, review the dispensary's

Standard Operating Procedures to ensure they are fit for purpose and reflect current best practice guideline and implement systems to monitor the quality of the dispensing service

- Carry out fire evacuation drills at each surgery.
- Continue to review patient satisfaction and make improvements in relation to access and the wider patient experience.
- Inform patients who have complained that if they remain unhappy with the practice's response they could contact the Parliamentary and Health Service Ombudsman.
- Provide chaperone and Mental Capacity Act training for all relevant staff.

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	

Belmont & Sherburn Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist advisor, a further CQC inspector and a CQC staff member observer.

Background to Belmont & Sherburn Medical Group

Belmont & Sherburn Medical Group provides care and treatment to around 7,100 patients. The practice is part of North Durham clinical commissioning group (CCG) and operates on a General Medical Services (GMS) contract agreement for general practice.

The practice provides services from the following addresses, which we visited during this inspection:

- Grey Avenue, Sherburn, Durham, County Durham, DH6 1JE
- Broomside Lane, Belmont, Durham, DH1 2QW

The Sherburn surgery is located in a purpose built two storey building. All patient facilities are on the ground floors. The Belmont surgery is based within a single storey building. There is on-site parking, accessible parking, an accessible WC, wheelchair and step-free access.

Patients can book appointments in person, on-line or by telephone.

Opening hours are as follows:

- Monday to Friday 8.15am to 6pm

Appointments with GPs are available at the following times:

- Monday to Friday - 8.30am to 12.00pm; then from 2.50pm to 6pm

The practice is part of a local hub which provides extended opening hours for patients; appointments are available Monday to Friday between 6.30pm and 8.45pm and Saturdays and Sundays from 8am to 6pm.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and County Durham and Darlington NHS Foundation Trust.

The practice has:

- two GP partners (both male), although only one is active in the practice,
- two salaried GPs (female),
- one nurse practitioner, one specialist nurse and two practice nurses (all female),
- a healthcare assistant,
- a practice manager,
- two dispensing officers and
- nine staff who carry out reception and administrative duties.

The age profile of the practice population is broadly in line with the local and national averages, but is made up of a slightly higher than average proportion of patients over the age 65 (23% compared to the national average of 17%). Information taken from Public Health England placed the area in which the practice is located in the fourth less deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments and had a number of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The 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 had received a DBS check. Some administrative staff who occasionally acted as chaperones had not received formal training but were aware of the requirements of the role.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- A fire risk assessment had been carried out for each site and managers told us that the fire protocol had been discussed with staff. However, fire evacuation drills had not been carried out to test that the plans were effective and ensure staff took action in line with the protocol.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

The practice had some systems for appropriate and safe handling of medicines, although the arrangements for dispensing medicines could be improved.

- Most of 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.
- We identified a concern in relation to medicines which needed to be stored in a refrigerator. Records of the refrigerator temperatures showed that on two days the maximum temperatures were very slightly above the recommended maximum of 8 degrees centigrade, at 9 and 10 degrees). Records showed that this had been due to restocking of the refrigerators. However, there were no formal mechanisms to inform staff on what action to take if the temperatures were high.

Are services safe?

- 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.
- Arrangements for dispensing medicines at the practice were not fully satisfactory. There was a GP responsible for the dispensary and both members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. However, the practice did not have a system in place to monitor the quality of the dispensing process.
- Dispensary staff showed us standard operating procedures (SOPs) which covered aspects of the dispensing process (these are written instructions about how to safely dispense medicines). Some of these were very brief and contained conflicting information about arrangements. For example, some made reference to former GPs and previous organisations which no longer existed and another SOP had the name of a different practice. It was not clear when documents had been reviewed; pages contained different dates so it was not always evident which policy was the current one.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- Activity was monitored and reviewed. This helped the practice 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, following an incident where a sample was labelled with the wrong patient name, staff introduced changes to help prevent a further reoccurrence. A procedure was implemented which instructed staff to check all labels against the practice's computerised patient record system before sending the sample off for analysis.
- 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.

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' 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.

Older people:

- Older patients who were frail or may have been vulnerable received a full assessment of their physical, mental and social needs.
- 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. Within the past 12 months 587 patients aged over 75 had received various health checks, including blood pressure and blood tests for monitoring purposes.
- The practice followed up on older patients discharged from hospital and 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.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 77.5%, which was broadly in line with 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 homeless people, travellers and those with a learning disability.

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

- 90.5% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months; above the national average of 83.7%.
- 96.3% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months; above the national average of 90.3%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, patients experiencing poor mental health had received

Are services effective?

(for example, treatment is effective)

discussion and advice about alcohol consumption (practice 96.3%, national average 90.7%) and had been offered advice about smoking cessation (practice 97.4%, national average 96.7%).

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results showed the practice achieved 99.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.7% and national average of 95.6%. The overall exception reporting rate was 10.3% compared with a national average of 9.9%. (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. We saw evidence of some completed clinical audits where improvements had been implemented and monitored.
- The practice was involved in quality improvement activity. They used benchmarking and performance information to identify areas and take action where they could improve. For example, they monitored prescribing data, referral rates and appointment availability and took action to improve where they identified they were not in line with comparators.

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.
- Most training was up to date; with the exception of chaperone and mental capacity act training for some staff.

- The practice provided staff with ongoing support. This included an induction process, coaching and mentoring, clinical supervision and support for revalidation.
- Managers told us that following changes to the management team over the past year, some staff appraisals had not been carried out. We saw these had all been scheduled in over the following three weeks.
- 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.

- 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.

- 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 and tackling obesity campaigns.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

- Although they had not undertaken any formal training, 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.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement 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 15 patient Care Quality Commission comment cards we received were positive about the service experienced.

Results from the July 2017 annual National GP Patient Survey showed some patients felt they were treated with compassion, dignity and respect. 235 surveys were sent out and 109 were returned. This represented about 1.5% of the practice population. Satisfaction scores were mainly below local and national averages. For example, of those who responded:

- 84% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national average of 89%.
- 80% of patients said the GP gave them enough time; CCG - 87%; national average - 86%.
- 91% of patients said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern; CCG - 87%; national average - 86%.
- 89% of patients said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 93% of patients said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 95% of patients said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.

- 60% of patients said they found the receptionists at the practice helpful; CCG - 89%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- 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 requested this information as part of the new patient registration process and during patient health checks and reviews. The practice's computer system alerted GPs if a patient was also a carer.

- The practice had identified 124 patients as carers (1.8% of the practice list).
- Carers were signposted to the local carers network to obtain specialist advice and support
- The practice offered health checks and influenza vaccinations for carers.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was followed by a home visit to review the family's needs and offering advice on how to find a support service.

Results from the National GP Patient Survey about patients' involvement in planning and making decisions about their care and treatment were lower than local and national averages. Of those who responded:

- 86% of patients said the last GP they saw was good at explaining tests and treatments, the same as the national average but below the CCG average of 88%.

Are services caring?

- 71% of patients said the last GP they saw was good at involving them in decisions about their care; CCG - 84%; national average - 82%.
- 86% of patients said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

We discussed the results of the Survey with managers; they were aware of the areas where performance was below expectations. There had been a number of changes and instability within both the clinical and reception teams over the past year. These issues had now been resolved and a

stable team was in place. More recent results from the Friends and Family Test showed improvements; for example in June 2017, 69% of respondents said they would recommend the practice, by November 2017 this had increased to 83%.

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.

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. Patient needs and preferences were taken into account.

- 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, home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- There was an on-site dispensary at the Sherburn surgery for patients who lived more than a mile from the nearest community pharmacy.

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 nurse practitioner also accommodated home visits for those who had difficulties getting to the practice.

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.
- An in-house diabetic foot screening service was available; providing care closer to home for patients.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child 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. For example, the practice was part of a local hub which provided extended opening hours for patients; appointments were available Monday to Friday between 6.30pm and 8.45pm and Saturdays and Sundays from 8am to 6pm.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice was the local area hub for physiotherapy services; providing access for all patients across Durham.
- A Men's Health clinic was provided at the practice; this was a separately commissioned service which aimed to treat patients (throughout the area) in primary care, rather than referring to secondary care services.

People whose circumstances make them vulnerable:

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

People 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.

Are services responsive to people's needs?

(for example, to feedback?)

- Information was available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had in-house counselling service available to patients.

Timely access to the service

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

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

None of the CQC comment cards completed by patients raised any concerns about access to the service. However, results from the July 2017 annual National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment was well below local and national averages. Of those who responded:

- 39% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and national average of 76%.
- 31% of patients said they could get through easily to the practice by phone; CCG – 73%; national average – 71%.
- 63% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG and national average – 84%.
- 51% of patients said their last appointment was convenient; CCG – 83%; national average – 81%.
- 34% of patients described their experience of making an appointment as good; CCG – 78%; national average – 73%.
- 49% of patients said they don't normally have to wait too long to be seen; CCG – 64%; national average – 58%.

We discussed the results of the Survey with managers; they were aware that over the past year there had been some difficulties for patients accessing the practice. They had carried out extensive work to understand the reasons for this and had made improvements. Various changes to the appointments system had been trialled. There was an ongoing, daily audit of appointments available and review

of clinicians' rotas. The audit showed that each week a number of face to face appointments and telephone appointments had not been booked and would have been available for patients.

Patients also had had access to the local extended hour's service since April 2017. Practice staff could make appointments for patients every day; between 6.30pm and 8.45pm and at weekends between 8am and 6pm.

One of the issues was that the clinicians' roles were not always made clear to patients. A poster had been devised which set out the type of condition that each clinician was able to treat. For example, in many cases the nurse practitioner was able to treat many patients who would have otherwise needed an appointment with a GP.

The data for the National Survey had been collected in January 2017 so did not reflect the most recent improvements. The practice was working with the Patient Participation Group (PPG) to develop a practice questionnaire to try to further understand the exact nature of patients' concerns about access. This was due to commence imminently.

On the day of the inspection there were urgent appointments available with a GP the same day; appointments with a nurse practitioner were also available that day. The next routine appointment with a GP was three weeks away but blocks of appointments were released at various stages, some the following day, others the following week, to try to manage demand more effectively.

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 complaints policy and procedures were in line with recognised guidance. Eight complaints had been received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

Are services responsive to people's needs? (for example, to feedback?)

- The practice responded to all complaints; however, they did not always make it clear in the response letter that if patients' remained unhappy they could contact the Parliamentary and Health Service Ombudsman.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. They

acted as a result to improve the quality of care. For example, following a complaint about a medical report, changes to the processes were implemented to ensure these were prepared and issued on a timely basis.

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 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.

- The provider is registered with CQC as a partnership of two GP partners. However, only one partner is active at the location; providing a clinical service and leadership with support from long-term salaried GPs.
- The active partner 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.
- Managers were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had processes in place to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision to deliver “high quality health care in a responsive, supportive, courteous and cost-effective manner”.

- There was a clear vision and set of values.
- Over the past year there had been some significant changes in how the partnership overseeing the practice operated. As a result only one of the partners was currently active. As a consequence the practice only had a short term supporting business plan in place for the next 12 months.
- 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.

Culture

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

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients.

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Managers were aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed, although at the time of the inspection some staff had not received their annual appraisal. 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 an emphasis on the safety and well-being of staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training

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

Managing risks, issues and performance

There were processes in place for managing risks, issues and performance.

- There was a 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

Are services well-led?

Good 

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

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 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 practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG). We spoke with four members; they told us the practice listened to them and made changes following suggestions made by the PPG, this included the development of a leaflet and posters to describe what each staff group within the practice was responsible for.
- Anonymised complaints and the results from the National GP Patient Survey were discussed with and reviewed by the PPG.
- 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 improvement at all levels. The practice was part of many local initiatives and led on new ways of working, including being a pilot site for summary care records and GP2GP (a system which enables patients' electronic health records to be transferred directly and securely between GP practices); staff worked closely with the development team to create guidance and training materials to support other practices. In implementing the system.
- 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.