Mansion House

Quality Report

Mansion House Surgery
Abbey Street
Stone
Staffordshire
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Tel: 01785 815555
Website: www.mansionhousesurgery.nhs.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?	Requires improvement
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. We previously inspected the service on 25 March 2015 and rated the service Good overall.

The key questions are rated as:

Are services safe? – Requires Improvement

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 Mansion House on 1 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had systems, processes and practices in place to protect people from potential abuse. Staff were aware of how to raise a safeguarding concern and had access to internal leads and contacts for external safeguarding agencies. However, not all staff had received up-to-date safeguarding training relevant to their role.
- The practice had 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.
- There were systems in place for identifying, assessing and mitigating most risks to the health and safety of patients and staff. However, not all environmental risks to patients and staff had been formally assessed.
- 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.

Summary of findings

- The partners had reviewed and increased its workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of patients and the demand for access to appointments.
- Not all staff had received essential training to enable them to carry out their duties safely.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Some patients found it difficult to make an appointment by telephone and told us appointments with GPs did not always run on time.
- The practice had extended its facilities and was well equipped and maintained to treat patients and meet their needs.
- The practice worked proactively with the patient participation group (PPG) to meet the needs of their patients and had consulted with them and members of the community before the building work on the recent extension began and the PPG officially opened the new building.
- There was a focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients. In particular: carry out risk assessments to identify and assess all environmental risks to patients and staff and identify the emergency medicines that are not suitable for the practice to stock. Ensure staff receive up-to-date essential training to include safe working practices and safeguarding.

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

- Ensure information about how to make a complaint is easily available for people to access.
- Ensure policies and procedures that govern activity are reviewed and updated to reflect practice.
- Review the monitoring of uncollected prescriptions in line with the practice policy.
- Consider more structured and on-going review of the advanced nurse practitioner and clinical prescribing pharmacist competency to support them in their evolving role.

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

Mansion House

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 advisor and a practice manager advisor.

Background to Mansion House

Mansion House is located in Stone, Staffordshire and delivers regulated activities from Mansion House only.

The practice is registered with the Care Quality Commission (CQC) as a partnership provider and holds a General Medical Services (GMS) contract with NHS England and provides a number of enhanced services to include minor surgery. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice is part of the NHS Stafford and Surrounds Clinical Commissioning Group (CCG).

The practice treats patients of all ages and provides a range of medical services. There are currently around 13,500 registered patients at the practice. The practice local area is one of less deprivation when compared with the local and national averages. The practice has a higher percentage of patients aged 49 and over compared to the national average and a lower number of patients aged 0–39 years. The practice has 66% of patients with a long-standing health condition compared to the CCG average of 55% and the national average of 53%, which could mean an increased demand for GP services.

The practice has recently been extended providing additional clinical and administrative rooms and facilities to offer new services going forward. The practice is owned and managed by a team of six GP partners who are supported by a salaried GP, registrar, two specialist clinicians, a nursing team, administration team and a management team. Opening hours are between 8am and 6pm Monday to Friday. Extended hours appointments are available alternate Monday evenings from 6.30pm to 8.15pm and Saturday mornings from 8.30am to 12.00pm for patients who would otherwise find it difficult to attend the practice during the day due to work or unforeseen circumstances.

The practice is a training practice and currently has one GP registrar. The practice is registered with a local university and works with them on research projects which aim to improve future patient care.

Additional information about the practice is available on their website: www.mansionhousesurgery.nhs.uk

Requires improvement

Are services safe?

Our findings

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

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

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. Staff knew how to identify and report safeguarding concerns and had access to internal leads and contacts for external safeguarding agencies. Staff shared examples of reporting safeguarding concerns and worked with other agencies to support patients and protect them from neglect and abuse. However, not all staff had received up-to-date safeguarding training relevant to their role.
- The practice had a range of safety policies in place which were communicated to staff but not all of these had been regularly reviewed. There were systems in place for identifying, assessing and mitigating most risks to the health and safety of patients and staff. There were records of safety checks undertaken. However, we found not all environmental health and safety risks to patients and staff had been formally assessed.
- We saw 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).
- Only clinical staff currently acted as chaperones. They were trained for the role and had received a DBS check. Notices were displayed in consultation and clinical rooms advising patients that chaperones were available if required. Patients spoken with were aware of this service provided.
- Not all staff had received up-to-date safety training or safeguarding training appropriate to their role.
- There was an effective system to manage infection prevention and control. There was a designated infection prevention and control (IPC) clinical lead in place. An IPC audit had been carried out in September 2017 and an action plan had been developed to address the improvements identified. A hand hygiene audit had also been carried out to assess staff compliance with the hand hygiene policy and observations and any concerns identified were documented and actioned.
- 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. Due to the difficulties experienced with recruiting to GP vacancies, the partners had proactively evolved their workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of their patients and the demands on the practice. Two advanced nurse practitioners (ANPs) and a clinical prescribing pharmacist had joined the practice since the last inspection.
- There was an effective induction system for temporary staff tailored to their role. For example, we saw checklists in place for locum staff that included checks made against their registration status, qualifications and training records. An induction pack was available and included fire procedures, external agency numbers, the appointment system, internal procedures, workflow information, staff team members and roles.
- 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.

Requires improvement

Are services safe?

- 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.
- We reviewed ten referral letters and saw these included all of the necessary information. The practice used the Map of Medicine to facilitate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and is effective in reducing referrals.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. However, at the time of the inspection not all of the recommended emergency medicines were held at the practice to include an injectable analgesic for pain relief and a medicine used to treat the possible side effect of insertion of intrauterine devices (coil). A risk assessment had not been carried out to identify the medicines that were not suitable to stock. The practice kept prescription stationery securely and monitored its use. However, the monitoring of uncollected prescriptions was not managed in line with the practice policy.
- 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.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice had appointed a clinical prescribing pharmacist providing an alternative and complimentary source of primary healthcare services traditionally provided by a GP. They held a prescribing qualification and provided patients with specialist information and advice about medicines and worked alongside the GPs and other clinicians in involving patients in regular reviews of their medicines. For example, changes in medicines following test results, hospital discharges and clinics held for long term conditions.The clinical prescribing pharmacist met with local pharmacies on a bi-monthly basis to share learning.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues in place and records of routine safety checks undertaken. However, an environmental risk assessment to identify hazards, risks and any control measures or corrective action had not been undertaken and the health and safety policy was last reviewed in 2013.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and procedure for recording and acting on significant events and incidents. There was a standard recording form available on the practice's computer system. Staff we spoke with told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure. Most staff were able to share an example of a recent significant event, the action taken and learning shared. Staff told us they were supported by managers when raising significant events. A communication book had been introduced and was located in the staff room to encourage incident reporting no matter how small.
- There were adequate systems for reviewing and investigating when things went wrong. The practice had recorded 16 significant events in the last 12 months. Events were recorded, investigated and shared practice wide during quarterly meetings held and action taken to improve safety in the practice. For example, following the use of an expired steroid medicine on a patient, procedures were reviewed to ensure medicines held at the practice were in date and expiry dates were checked before using them.
- There was an effective system in place led by the practice pharmacist to log, review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may

Requires improvement

Are services safe?

affect patient safety. Following an alert being received, the practice checked to ensure that patients were not affected by the medicines or equipment involved and took appropriate on going action where required.

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.
- The practice was comparable to the Clinical Commissioning Group (CCG) and national averages for antibiotic prescribing. The number of items the practice prescribed was 1.067 items compared to the CCG average of 1.195 and the national average of 1.085.
- The percentage of high risk antibiotics prescribed (Co-amoxiclav, Cephalosporins or Quinolones) was 9.4%, compared to the CCG of 10.9% the national average of 8.94%. The practice told us there had been a high use of locum GPs used last year and they were educating locum staff in relation to prescribing these medicines and were working with the CCG medicines optimisation team in appropriate antibiotic prescribing.
- 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:

- The practice was currently involved in a pilot using NHS England resilience funds to trial an advanced nurse practitioner having a weekly surgery at four of the eight local nursing and residential homes in Stone. The purpose was to improve continuity of care for patients, avoid and reduce hospital admissions in addition to offering support and advice to staff over the telephone and during visits and increase the visibility of support from the practice.
- Older patients who were frail or vulnerable were identified and received a full assessment of their physical, mental and social needs.
- 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.
- Patients over the age of 75 years had a named GP.

People with long-term conditions:

- The practice offered a number of clinics for patients with long-term conditions. Patients had a structured annual review to check their health and medicines needs were being met. Patients were provided with a management plan developed in partnership with them and agreed targets set for the next review. 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.
- Data for 2016/17 showed 91.4% of patients with chronic obstructive pulmonary disease (COPD) had had a review undertaken including an assessment of breathlessness using a recognised scale in the preceding 12 months. This was comparable with the CCG average of 94% and the national average of 90%. COPD is a chronic lung disease. The practice exception reporting rate of 17% was the same as the CCG average and above the England average of 11%.
- The percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 77% compared with the CCG of 80% and the national average of 79%. The practice exception reporting rate of 15% was higher than the CCG average of 13% and the national average of 12%.

Families, children and young people:

- Child immunisations were offered by the practice and carried out in line with the national childhood vaccination programme. Patients who missed any of their immunisations were monitored and recalled. Uptake rates for the vaccines given to under two year olds were above the target percentage of 90%. The uptake rates for vaccines given to five year olds ranged from 91% to 98%.

Good

Are services effective?

(for example, treatment is effective)

- Antenatal clinics were held by appointment on a Tuesday afternoon with the visiting community midwife. health surveillance clinics where the mother and baby were reviewed.
- In order to increase the availability of after school appointments, the practice had provided a number of advanced nurse practitioner appointments after 4pm.
- Full contraception services were offered including implants and intrauterine contraceptive devices (coils).

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

- The practice's uptake for cervical screening was 78%, which was comparable with the Clinical Commissioning Group average of 80% and the national average of 81%. The practice exception reporting of 1% was below the CCG average of 5% and the national average of 6%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Information about this vaccine was readily accessible and displayed in the waiting area and letters were sent to patients.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data provided by the practice showed they had completed 404 of these health checks for the period 2016/17. 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 hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 74 registered patients with a learning disability cared for in local care homes and in their own homes. Sixteen of these patients had received an annual review. The practice had a designated GP who was the learning disability lead and was involved in the review of these patients and was working to increase the number of reviews undertaken.
- The practice had identified (2%) of the patient list as carers and signposted them to local services offering support and guidance.

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

- Nurse led clinics were provided on a monthly basis in conjunction with the Community Mental Health Nurse (CMHN). The practice had a designated nurse dementia lead.
- The practice hosted a weekly memory clinic for their patients and for patients from two neighbouring practices to avoid patients travelling to Stafford for an assessment. The practice was working towards becoming a dementia friendly practice supporting those with the diagnosis to feel comfortable accessing appointments.
- 73% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months compared with the CCG average of 82% and the national average of 84%.The practice exception reporting rate of 7% was lower than the CCG average of 9% and the same as the national average.
- 92% 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 CCG average of 94% and the national average of 90%.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had carried out audits to include a full cycle audit on newly diagnosed patients with asthma. The first audit identified 57% of these patients had been managed correctly at first presentation. The most recent audit undertaken showed this had improved to 83%.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality

Good

Are services effective?

(for example, treatment is effective)

of general practice and reward good practice). The most recent published results for 2016/17 showed the practice had achieved 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and the national average of 95%. The practice clinical exception rate of 15% was above the CCG average of 12% and the national average of 10%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

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 opportunities for personal development. Newly appointed staff received an induction to their work. Records of staff skills, qualifications and training were maintained. However, we identified not all staff had received up-to-date essential training to enable them to carry out their duties safely. For example, safeguarding, infection control and fire safety awareness. The provider acknowledged that not all staff were up to date with their training requirements. Following the inspection they sent us confirmation that they had sourced an electronic training programme and this had been activated for all staff. They told us staff would be provided with the time to complete any outstanding training. Fire safety awareness training was scheduled to take place the day after the inspection on 2 November 2017.
- Staff were encouraged and given opportunities to develop. For example an advanced nurse practitioner (ANP) was being supported to extend their role within the community and partake in a pilot project across care and nursing homes within the locality. An ANP had expressed an interest in women's health and was also being supported to undertake a diploma to ensure a continued service for patients in the future.
- The practice provided staff with ongoing support. This included an induction process, appraisals, tutorials, clinical supervision, lunchtime briefing sessions and support for revalidation. Two clinicians we spoke with considered the practice could provide more structured opportunities to discuss their learning.
- 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. Meetings were held with external healthcare partners to discuss patients with complex needs.

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. For example, patients with long term conditions.
- 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 and supported and signposted patients that required support.

Good

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.

- 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.
- Clinicians were able to share examples of how and what procedures they obtained consent for. For example, written consent was obtained for immunisations, minor surgery, contraceptive intrauterine devices (coil) and implants.

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 area to discuss their needs.
- Six of the seven patient Care Quality Commission comment cards we received were very positive about the service experienced. Five patients described the standard of service as 'excellent'. Another patient commented that they always received the highest standard of care.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and twenty three surveys were sent out and 124 were returned. Patient satisfaction scores for consultations with GPs and nurses were mainly in line or above the CCG and national averages. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 93% of patients who responded said the GP gave them enough time; compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; compared with the clinical commissioning group (CCG) and the national averages of 95%.
- 93% of patients who responded said the last GP they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 87% of patients who responded said the nurse was good at listening to them; compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 92% of patients who responded said the nurse gave them enough time; compared with the clinical commissioning group (CCG) average of 94% and the national average of 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; which was the same as the clinical commissioning group (CCG) and the national averages.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 82% of patients who responded said they found the receptionists at the practice helpful; compared with the clinical commissioning group (CCG) and the national averages of 87%.

The practice had reviewed the results, compared these against two other local GP practices and had completed a report based on the findings. They considered their practice generally performed well in terms of patient experience. The results of the survey had been shared with staff and the patient participation group.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care. Interpretation services were available for patients who did not have English as a first language. Although notices were not displayed in the reception areas advising patients of this service, the staff we spoke with were able to tell us how they would support a patient with accessing this external service in addition to obtaining information in a variety of formats, for example, large print.

Good

Are services caring?

- 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.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs and staff if a patient was also a carer and referred them to a local voluntary carers association The practice had identified 293 patients as carers (2% of the practice list).

- Staff told us that if families had experienced bereavement, they passed on their condolences and signposted them to a counselling service hosted by a voluntary organisation who visited the practice on a regular basis.

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 mainly in line with local and national averages:

- 81% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) and the national averages of 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; compared with the clinical commissioning group (CCG) and the national averages of 90%.
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- A private area was available should a patient wish to discuss sensitive issues or their prescriptions.

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 and advanced booking of appointments in addition to providing weekly visits to a number of local residential and nursing homes.
- The practice had reviewed and increased its workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of patients and the demand for access to appointments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. The practice had recently been extended to provide additional clinical and administration space to develop and offer new services to its population.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations were available with a duty GP and the clinical prescribing pharmacist for patients unable to access the practice within normal opening times. Home visits were provided for patients who were housebound or had enhanced needs.
- 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.
- An advanced nurse practitioner made weekly visits to nursing homes within the locality and offered support and advice over the telephone as well as during weekly visits and carried out holistic assessments.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- The practice provided a number of long term condition clinics in order to support patients to manage these conditions, monitor their wellbeing and develop management plans in conjunction with them.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with external health professionals to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had systems in place 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.
- Appointments were offered outside school hours for school aged patients and children were seen on the same day. In order to increase the availability of appointments, the practice had provided a number of advanced nurse practitioner appointments after 4pm.
- Antenatal clinics were held by appointment on a Tuesday afternoon with the visiting community midwife. health surveillance clinics where the mother and baby were reviewed.
- Full contraception services were offered including implants and intrauterine contraceptive devices (coils). 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 appointments were offered on alternate Monday evenings and Saturday mornings in order to offer the greatest flexibility for patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- NHS Health Checks were provided for patients aged 40 to 74 and patients were given lifestyle advice on exercise and diet.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice was proactive in supporting the local authority with any patients with safeguarding issues and had met with social workers and attended multi-disciplinary team meetings to support other clinicians in the care of these patients.
- The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.

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.
- Nurse led clinics were provided on a monthly basis in conjunction with the Community Mental Health Nurse (CMHN). The practice had a designated nurse dementia lead.
- The practice hosted a weekly memory clinic for their patients and for patients from two neighbouring practices to avoid patients travelling to Stafford for an assessment.The practice was working towards becoming a dementia friendly practice supporting those with the diagnosis to feel comfortable accessing appointments.

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 access to initial assessment, test results, diagnosis and treatment.
- Some patients found it difficult to make an appointment by telephone and told us appointments with GPs did not always run on time. We saw patients were advised if their appointments were running late.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was broadly comparable to the local and national averages, except for telephone access, experience of making an appointment and wait times. For example:

- 69% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 42% of patients who responded said they could get through easily to the practice by phone; compared with the clinical commissioning group (CCG) average of 72% and the national average of 71%.
- 85% 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; compared with the clinical commissioning group (CCG) average of 86% and the national average of 76%.
- 79% of patients who responded said their last appointment was convenient; compared with the clinical commissioning group (CCG) and the national average of 81%.
- 65% of patients who responded described their experience of making an appointment as good; compared with the clinical commissioning group (CCG) average of 72% and the national average of 73%.
- 36% of patients who responded said they don't normally have to wait too long to be seen; compared with the clinical commissioning group (CCG) average of 57% and the national average of 58%.

This was supported by observations and discussions held with patients on the day of inspection and completed comment cards. The practice acknowledged that access by telephone continued to be problematic for patients and as a result a new telephone system had been installed and the working of reception staff had been restructured. The new telephone system had an option for a 24 hour a day, seven day a week cancellation line whereby patients were able to cancel their appointment by leaving a brief

Good

Are services responsive to people's needs?

(for example, to feedback?)

message on the answer phone which was picked up as soon as the practice opened. This was to try and avoid patients failing to attend appointments. Patients we spoke with told us they would welcome being told what position they were in the queue when contacting the practice by telephone.

The practice were embracing the GP Forward View 10 high impact actions to release capacity and were working through a number of streams to support this. For example, reception staff had received training from the practice clinical prescribing pharmacist on the services offered by local pharmacies through the pharmacy first scheme so they could actively signpost patients. (A scheme where the local community pharmacist can provide a range of free advice on the best treatment for a wide range of illnesses and minor ailments so that patients may not need to make an appointment to see a GP or advanced nurse practitioner).

The practice was proactively working to improve access to appointments. Two advanced nurse practitioners and a clinical prescribing pharmacist had been appointed to reduce the demand on GP appointments and vacant GP post was being backfilled by regular locum GPs. Patients and staff spoken with were complimentary about the ANP's and clinical prescribing pharmacist. One patient told us the ANPs were a 'fantastic addition to the surgery'. The practice outgoing telephone message included a recorded statement from one of the GP partners asking patients not to be offended when asked by reception staff what their reason for needing an appointment was. This was to assist reception staff book patients in with the most appropriate clinician to get the best care they needed or actively signpost them to more appropriate services. The practice also monitored and followed up patients that did not attend their appointments (DNA's) as recommended by the previous inspection. This process was agreed and encouraged by the patient participation group in response to the number of DNA's the practice was experiencing.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was not readily accessible in the practice and information on the practice website signposted patients to the practice manager. The majority of patients we spoke were not aware of how to make a complaint. Reception staff had access to the complaints process and told us leaflets explaining the process were shared with new patients registering at the practice in addition to other leaflets including patient information. We saw that the complaint leaflet and letters of response to complainants included details of how to complain to the NHS Ombudsman should a patient not be satisfied with the outcome of their complaint.
- The practice manager was the designated lead for managing complaints. The complaint policy and procedures were in line with recognised guidance. We saw 26 complaints had been recorded this year. We reviewed four complaints and found that they were satisfactorily handled in a timely way. An analysis of trends identified the lack of appointments was a common theme that the practice was taking action to address.

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 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. For example, due to the difficulties recruiting to GP vacancies the practice had reviewed and increased its workforce and skill mix. The practice had employed two advanced nurse practitioners (ANPs) and a clinical prescribing pharmacist to reduce the demand on GP appointments and to provide an alternative complimentary source of primary healthcare alongside services traditionally provided by its GPs.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff had lead roles and were aware of their roles and responsibilities.
- 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.

- The practice had a mission statement and a minimum standards agreement that had been developed in conjunction with staff. This was to work in partnership with their patients, understanding their needs and delivering the highest standards of medical care to the community. Staff spoken with understood the vision, values and strategy and their role in achieving them however, the mission statement was not accessible to patients.
- The practice planned its services to meet the needs of the practice population. For example, the practice had increased its capacity for urgent care by recruiting ANPs and increasing efficiency by making sure the right staff members were doing the right work.

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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and had access to a policy in the event of needing to raise concerns in relation to staff practice in the workplace.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received an annual appraisal in the last year and 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 attending various meetings held in addition to professional development and evaluation of their clinical work.
- The practice actively promoted equality and diversity. However, staff had not yet received training in this area. Staff felt they were treated equally and reported 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,

Are services well-led?

Good

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies and procedures however, we saw a number of these required review.

Managing risks, issues and performance

There were processes 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. However, we found an environmental health and safety risk assessment had been completed to identify hazards and mitigate potential risks.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through checks and discussions of their consultations, prescribing and referral decisions. Practice leaders had oversight of incidents, and complaints in addition to external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.
- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice had plans in place 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 submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) that consisted of ten core members. The PPG met quarterly and meetings were chaired by the practice manager. During the inspection we met with two members of the group. They told us they were actively involved with meetings with the practice and the community before the building work on extended the practice began. Plans were shared with them and the local community during an open evening and views and suggested changes were listened to and acted upon. For example, a request for a meeting room and changes to the proposed reception area to improve patient experience. A member of the group and their family members officially opened the extended building. We saw PPG meetings were recorded but not shared practice wide and there was limited information available to actively encourage new members to the group that reflected the diversity of the practice population.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. The

Are services well-led?

Good

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

practice was running a pilot using NHS resilience money to trial an advanced nursing practitioner providing a weekly surgery at four nursing homes. This enabled the practice to work more effectively with the homes and provide a plan of care for patients and avoid and reduce hospital admissions and the demand on GPs.

- The practice had recently reviewed and transformed the way patient correspondence was processed within the practice releasing GP time for providing direct clinical care.
- The practice was working with two other practices to develop their locality and for sharing best practice. The GPs and practice managers met regularly to take the work forward and to strengthen and support each other and ensure future sustainability.
- 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.
- The practice was a training practice and currently had one GP registrar. The practice was registered with a local university and worked with them on research projects which aimed to improve future patient care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • A risk assessment had not been completed to support the decision not to stock the emergency medicines as recommended. • Not all environmental health and safety risks to patients and staff had been formally assessed. • Staff had not received up-to-date essential training including safe working practices and safeguarding. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.