Dr N H Gibson and Partners

Inspection report

Bodriggy Health Centre
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Hayle
Cornwall
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection March 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection of Dr N H Gibson and partners known as 'Bodriggy Health Centre' on 12 April 2018. The inspection was a routine inspection as part of our inspection schedule.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Feedback from all 22 patients at the inspection, verified staff involved and treated them with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. Routine appointments for both GPs and nurses were available on the day.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice had a strong focus on continuity of care with personal GP lists. Succession planning was underway for when staff retired and projected increases in the patient list size due to new housing developments in the area.

We saw one area of outstanding practice:

A holistic approach improving patients quality of life is promoted with several initiatives set up and funded by the practice, including: arts for health (run at the practice for patients), a dose of nature (gardening for mental and physical well-being) and the Hayle Breezers Group (for patients living with chronic respiratory conditions).

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

- Review the arrangements for the secure storage and tracking of prescription forms, in accordance with national guidance.
- Review the system for managing codes attached to patient health priorities so that they are regularly monitored for assurance of accuracy and accessibility.
- Review the Disclosure and Barring Service (DBS) policy to demonstrate how the criteria for new checks are needed. This includes carrying out risk assessments to support the decision made.
- Review the quality assurance system to include: Monitoring when GPs and any locum GPs used are due to revalidate; Increased frequency of clinical audit to improve patient care, and reviewing and updating policies.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a practice manager adviser.

Background to Dr N H Gibson and Partners

Dr N H Gibson and partners run one registered location at the 'Bodriggy Health Centre', which was inspected on 12 April 2018. This was a comprehensive inspection. The practice is located at:

60 Queensway

Hayle

Cornwall

TR27 4PB

The practice provides a primary medical service to 11, 095 patients of a diverse age group. The practice population is in the fourth deprivation decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. Particular areas of Hayle and the surrounding villages have much higher levels of deprivation. A higher percentage of people in Hayle under 65 years of age report themselves as having a limiting long-term illness (14.4%) compared with 13.5% of people across Cornwall and the Isles of Scilly and 10.8% across the South West. The practice focusses on raising awareness of health promotion and self-management to improve patient's quality of life. There is a practice age distribution of male and female patient's equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 78 years and females to 83 years.

There is a team of eight GPs partners, five male and three female. Some work part time and some full time. Partners hold managerial and financial responsibility for running the business. The team are supported by a practice manager, four practice nurses, an assistant nurse practitioner, three healthcare assistants and additional administration staff.

Dr N H Gibson and partners is an approved training practice providing vocational placements for GPs and medical students. Two GP partners are approved to provide vocational training for GPs, second year post qualification doctors and medical students. A GP registrar was due to start their placement the following week.

Patients using the practice also have access to community nurses, mental health teams and health visitors. Other health care professionals visit the practice on a regular basis.

The practice is open between 8am and 6:30pm Monday to Friday. Appointments are available from 8am every morning and 6pm daily. Extended hours opening is available on a Tuesday or Thursday from 7am to 8am and 6.30pm to 8pm. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments. Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment. We reviewed the recruitment policy. The policy did not include criteria about when new Disclosure and Barring Service checks were required, at what level for a role or whether a risk assessment should be completed to support any decision made not to obtain a check.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- Leaders were aware of the impact of changes in list size and recruited staff accordingly. For example, the practice had anticipated an increase in list size to 13,000 patients in the next five years and a further expansion to 15,000 some years later due to new house developments in the area. Succession planning was in place to recruit new staff when longer serving staff retired.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. However, improvement was needed

- The care records we saw showed that information needed to deliver safe care and treatment was recorded. However, we discussed five care records with GP partners when they showed us the system for management of patient information. GPs demonstrated there was diagnosis or health issue summary section that could be used but did not complete this as they felt they were fully conversant with their patients history. The IT system was set up with codes, providing automatic prioritisation of diagnoses but we found these were inappropriate. For example, a normal cervical smear result was given a high priority but a malignant melanoma excision was given a moderate (lower) priority. This presented a potential risk for patients receiving follow on care. High priority diagnoses were not prominent or easily accessible for any new staff, including locum GPs to be aware of. We discussed this at feedback and GPs told us the read code system was being upgraded to a structured clinical vocabulary for use in an electronic health record used worldwide. Immediately following the inspection, the

Good

Are services safe?

practice verified it had searched all patient records and manually changed read codes against diagnoses so an appropriate priority level was prominent and accessible within patient notes.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

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 and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients were able to access equipment for home testing, such as Blood Pressure (BP) machines for reporting results back to their GP to facilitate diagnosis and treatment. Near patient testing equipment was used at the practice to monitor patients on anti-blood clotting medicine (warfarin) providing immediate results and changes to dosage where necessary.
- Staff used appropriate tools to assess the level of pain in patients, where clinically appropriate.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicine.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Since the last inspection the practice had employed a pharmacist whose role included reviewing patient medicines and liaising with them if any changes had been made.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

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% or above. For example, vaccination rates for children under 2 years ranged between 95% and 98%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Failed attendance were reviewed weekly by the

safeguarding lead GP. Examples discussed demonstrated the practice worked closely with other professionals such as the health visiting team if they had any concerns.

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

- The practice's uptake for cervical screening was 75%, which was comparable with local (75%) and national (72%) uptakes. There is an 80% coverage target for the national screening programme. The practice attempted to increase awareness of this programme amongst eligible women by using all patient contact as an opportunity to support and arrange appointments with them.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients at risk of leg ulceration due to their condition were monitored closely at a combined initiative with secondary services, known as the 'Centipede Club'. The group provided proactive and preventative care to reduce the risk of unplanned hospital admission, antibiotic therapy, pain and discomfort for patients. Practice nurses staffed regular sessions at the 'Centipede Club' with community nurses.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 96% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the national average of 84%.
- 97% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the national average of 91%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 96% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was comparable to the national average of 96%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided as a result of safety alerts and clinical commissioning group initiated audits. For example, the practice conducted monthly audits of the monitoring of patients who were prescribed high risk medicines. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had jointly funded a pharmacist role with the clinical commissioning group. The pharmacist supported the practice with reviewing medicines for efficiency and appropriateness. .

Exception reporting for where patients had not received an annual review, was higher in some clinical areas:

Good

Are services effective?

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions was 16.6% (CCG 12.2% and National 7.7%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 21.4% (CCG 15.9% and National 12.5%).
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 24.8% (CCG 7% and National 6.8%).

We discussed the high exception rates with the practice, which had reduced in the financial year ending 31 March 2018. The unpublished data the practice shared data with us showed a 7% reduction in the number of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan exception reported with a comprehensive care plan.

GPs explained areas of Hayle and the surrounding villages had much higher levels of deprivation, which in turn affected patient engagement with health monitoring. The practice was aware a higher percentage of people in Hayle under 65 years of age who reported themselves as having a limiting long-term illness (14.4%) compared with 13.5% of people across Cornwall and the Isles of Scilly and 10.8% across the South West. The practice explained how it focussed on raising awareness of health promotion and self-management to improve the quality of life for patients. Patients were invited three times at regular intervals throughout the year. Exception reporting was signed off by the patient's GP if they failed to respond based on clinical risk.

- GPs used evidence based medicine and avoided over medicalisation of problems for older and frail patients. For example, the practice had lower prescribing rates of hypnotic (sleep inducing medicine) at 0.46 (CCG 0.99 and national 0.9). This approach helped to reduce the risk of falls leading to fractures associated with older/ frail patients prescribed this medicine.
- The practice used information about care and treatment to make improvements. A recent example was the March 2018 MHRA (Medicines and Healthcare products Regulatory Agency) alert about a medicine commonly used to suppress the immune system after organ transplant. Searches had been undertaken and appropriate action taken. We tracked two other safety alerts about medicines, including one for medicines used in epilepsy which were considered high risk in women of child bearing age. Patients on this medicine were identified, reviewed, advice given about the risks associated with pregnancy and changes made where necessary.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Good

Are services effective?

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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 practice initiated monitoring and management of their own health. For example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Staff communicated with people 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 carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- New online services were under development and due to be available in the middle of June 2018. The new system would allow patients to consult with their own NHS GP by completing an online form to obtain instant self help advice and signposting to other services such as pharmacies and other healthcare services.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Nursing staff had evaluated patient feedback and demonstrated changes made to services to improve patient experience. For example, nursing appointments had been re-organised so they could be delivered across the week with appropriately skilled staff and timeslots available. Examples included long blocks of an hour for cervical screening and ear irrigation appointments. Equipment had been centralised and specific clinics allocated to named nurses reviewing patients with long term conditions. Reception staff had been provided with a skillset of all the practice nurses and health care assistants outlining the procedures they trained and competent to undertake.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice worked closely with a nearby care home providing specialist palliative care as an alternative to hospital admission. GPs liaised with the patient's normal GP practice and carried out a home visit the same day to assess and set up anticipatory medicines and other health related arrangements.

People with long-term conditions:

- Changes to the recall system six months ago enabled patients with a long-term condition to receive an annual review to check their health and medicines needs were being appropriately met. Since these changes, multiple conditions could be reviewed at one appointment, and consultation times made flexible to meet each patient's specific needs.
- Near patient testing was available for patients on anti-blood clotting medicines. Patients were able to receive immediate results and advice when the dosage needed to be adjusted.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice facilitated care at home for patients with chronic health conditions, where exacerbation of ill health would normally require hospital admission. This included supporting the acute care at home team so patients were able to receive intravenous antibiotics when clinically required at home.
- Patients with, or at risk of developing, leg ulcers were able to access a clinic (The Centipede Club), which was a collaborative project with tissue viability nurse specialists being run weekly at the community centre. This service also provided patients who could be at risk of social isolation with the opportunity to meet new people and make friends.
- The practice had helped set up the Hayle Breezers Group, providing support for patients with chronic obstructive pulmonary disease. Patients met regularly for exercise and were able to access respiratory specialists for advice.

Families, children and young people:

Good

Are services responsive to people's needs?

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice was young person friendly having achieved validation from the Kernow Savvy scheme. The practice worked closely with the Hayle Community School to educate and provide proactive health advice to reduce the risk of unplanned pregnancies and sexually transmitted infections. If a pupil required an appointment with the GP, the green card system enabled them to access services without an appointment and without having to provide an explanation.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were offered once a week on Tuesday or Thursday morning and evening.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including families at risk of domestic abuse, homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Patients with a learning disability had access to longer appointments for an annual health check, which was co-ordinated with the learning disability team supporting them.
- A GP partner specialised in the shared care of patients in recovery from substance misuse. Patients were able to receive support and treatment closer to home.

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.
- A consultant psychiatrist held clinics for patients with mental health problems at the practice promoting better shared care. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Third sector agencies providing support for patients recovering from substance or alcohol addiction used practice facilities so patients were able access this service closer to home.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- 91% patients responding in the national GP Survey reported that the appointment system was easy to use. This was above the local (82%) and national (72%) averages.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, patients had been having difficulty logging in on the self-check in system on arrival for their appointment. The actions taken included liaising with the computer system provider to improve this situation. The matter was discussed at a patient participation meeting and patients informed that the practice continued to monitor the situation.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. This included: proactive planning to increase staffing in alignment with anticipated increased patient list numbers resulting from housing developments in the area. Other actions included additional staff cover to respond to the influx of up to 2000 temporary patient contacts during the holiday season.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

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

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. Three members of the patient participation group (PPG) commented that there was a holistic approach at the practice. They told us GP partners regularly attended PPG meetings, listened and took action to improve patient experience.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We reviewed three complaints and saw the practice appropriately offered resolution meetings and gave an apology when things went wrong.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. These were undertaken by two GP partners who were approved appraisers. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. The practice had organised an annual away day for staff at a garden project. This enabled staff time to reflect, do team building exercises and experience first-hand what their patients could experience if signposted to the project.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity by setting this topic as a mandatory training subject for staff to complete on the online training resource. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Good

Are services well-led?

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The practice had collaborated with two neighbouring practices and was advertising to recruit a nurse co-ordinator. The role and responsibilities for this new position included reviewing any housebound patients with long term conditions and/or vulnerable patients to ensure any identified risks were reduced where possible.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit initiated by the clinical commissioning group had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. The practice recognised there were opportunities to develop the audit approach further, by carrying out practice led audits.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. The practice had been an approved training practice for many years proving placements for GP registrars and medical students. Two of the GP partners were appraisers in the locality, providing support and guidance on professional development for local GPs.

Good

Are services well-led?

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.