Moor Park Medical Practice

Inspection report

The Bluebell Building
Barkerend Health Centre, Barkerend Road
Bradford
West Yorkshire
BD3 8QH
Tel: 01274 778400
www.moorparkmedicalpractice.nhs.uk

Date of inspection visit: 10 October 2018 to 10 October 2018
Date of publication: This is auto-populated when the report is published

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. The practice had been previously inspected in November 2014 when it was rated as Good overall.

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 at Moor Park Medical Practice name on 10 October 2018 as part of our inspection programme.

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 actively 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.
- The practice had recognised the specific need of their patient population and had developed services and trained staff to meet this need.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Recent feedback indicated patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice was open to innovation and had participated in a number of local initiatives such as those in relation to extended hours and care navigation.
- The practice demonstrated that effective management and governance processes were in place.

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

- Continue to review and improve areas of satisfaction in relation to patient consultations and access to appointments.
- Continue to review and improve performance with regard to cervical, breast and bowel screening.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief 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 second CQC inspector.

Background to Moor Park Medical Practice

Moor Park Medical Practice is located in The Bluebell Building Barkerend Health Centre, Barkerend Road, Bradford, West Yorkshire, BD3 8QH. The building is a single storey purpose built unit, and is situated in a residential area of inner city Bradford. Facilities include a range of consulting and treatment rooms with a reception area and supporting administrative areas. The building was accessible for those with a physical disability.

The practice has a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and the commissioning body for delivering primary care services. The practice currently provides services for around 2,890 patients. The practice is a member of the NHS Bradford City Clinical Commissioning Group (CCG.)

The practice is registered with the Care Quality Commission to deliver services in relation to:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Maternity and midwifery services

A wide range of services are available at the practice and these include:

- Dementia support
- Learning disability support
- Immunisations and vaccinations
- Cytology (cervical smears)
- Chronic disease management

The population age profile shows that it has a high number of patients aged under 18 years at 33% compared to a CCG average of 31% and a national average of 21%. Average life expectancy for the practice population is 74 years for males and 80 years for females (CCG average is 75 years and 80 years respectively and the England average is 79 years and 83 years respectively). The practice serves some areas of higher than average deprivation being ranked in the first decile of multiple deprivation (the first decile being the most deprived and the tenth decile being the least deprived). The practice has a mixed population with 63% of patients identifying as Asian, 30% as White British, 3% mixed race, 2% Black and 2% Other.

Clinical services are provided by one GP (male), three regular locum GPs (two male, one female), one trainee Advanced Nurse Practitioner/ nurse prescriber (female), one practice nurse (female), two health care assistants (both female), and a pharmacist (male). The clinical team is supported by a practice manager, a patient engagement lead and a team of reception and administration staff.

The practice opening times are Monday, Tuesday, Wednesday and Friday 8:00am – 6:30pm, and between 8:00am to 1:00pm on Thursday. From 1:00pm on Thursday services were covered by another practice which operates from the same building. Appointments can be booked in person, via telephone and online.

As part of a Federation initiative patients from the practice could access extended hours services at three other practices from Monday to Friday 6pm to 9pm, and at weekends from 9am to 1pm.

The practice appointments include:

- Pre-bookable appointments
- Urgent and on the day appointments
- Telephone consultations
- Home visits

When the practice is closed, urgent healthcare advice that is not a 999 emergency is provided by telephoning the local Out of Hours NHS 111 service.

The practice displays the rating of the previous Care Quality Commission inspection carried out in November 2014 both in the waiting area and on the practice website.

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, and we heard from the practice how in the past concerns had been escalated to other stakeholders. Reports and learning from safeguarding incidents were discussed at team meetings and were available to staff via the minutes of these meetings. The practice recorded and coded on their patient record system if a child had not attended an appointment and followed up such incidences.
- Staff who acted as chaperones were trained for their role and had received a 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 and on an ongoing basis. We found recruitment and personnel files to be well laid out and contained the correct level of information.
- 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.
- Whilst the use of agency staff was limited we saw that there was an effective induction system for such 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.
- The practice was supporting a nurse to become an advanced nurse practitioner (ANP). We saw that the principal GP had given clinical support and guidance to the trainee ANP after each session.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results and we saw that these were checked on a daily basis.
- 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.
- In addition to more formal meetings the practice staff met for an informal meeting twice a day before each session and were able to discuss ongoing or developing issues.

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

Good

Are services safe?

antimicrobial stewardship in line with local and national guidance. We saw that performance in relation to antibacterial prescribing was good and that audit work had been carried out in relation to this.

- 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. This involved both GPs and the pharmacist within the practice.
- The practice had shared care agreements in place for patients who were in receipt of disease modifying antirheumatic drugs and required additional monitoring and support.

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 discussed incidents at both clinical and full team meetings.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. We saw that recent alerts had been assessed and actioned in line with guidance.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Updates and changes to guidance and approaches to service delivery were discussed at monthly clinical meetings.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may 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 or otherwise vulnerable received a review which included a review of medication. Patients over 75 years were invited by the practice for a health check.
- 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. The practice maintained a close working relationship with the community matron.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Unverified data showed that the uptake for Flu vaccinations for over 65s was 87% in 2017/18.

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. We saw that multidisciplinary team meetings were held regularly. To support this work the practice maintained detailed registers of patients with specific conditions.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, we saw that the practice had supported both a practice nurse and health care assistant to receive additional training in relation to diabetes.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered 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 it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension) and developed detailed care plans which it shared with patients when appropriate.
- Performance in relation to long-term conditions was either slightly above or otherwise comparable to local and national averages. For example, 85%of patients with asthma listed on the practice register had received an asthma review in the preceding 12 months compared to a CCG average of 80% and the national average of 76%.
- It was however noted that exception reporting for certain conditions such as atrial fibrillation (33%) was higher than average. We discussed this with the practice who informed us that they had a protocol for exception reporting and that this was rigorously implemented. In addition, certain conditions had low overall numbers and any non-cooperation by patients with regard to their treatment had a disproportionate impact on exception reporting figures.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%. The practice told us that it closely monitored uptake and followed up those children who had not received vaccinations.

Good

Are services effective?

- Members of the practice team met regularly with health visitors to discuss safeguarding concerns or children with complex needs.
- The practice had arrangements for recording and following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 68%, which was below the 80% coverage target for the national screening programme (CCG and national averages were 61% and 72% respectively. We spoke with the practice regarding this performance and they told us that they worked closely with their patient population and recalled them as required. When a patient had missed an appointment, staff contacted them to promote attendance.
- Performance in relation to breast and bowel cancer screening was mixed, being above local CCG averages but below national averages. The practice's uptake for breast cancer screening was 59% compared to the CCG average of 56% and the national average of 70%. For bowel cancer screening the practice achieved 51% compared to a CCG average of 35% and a national average of 54%. We discussed this performance with the practice and they told us that in the case of bowel cancer screening, patients who have been invited but had not participated were sent a letter and information regarding bowel cancer to raise awareness of the need to submit a sample. To promote breast cancer screening as well as opportunistic discussion with patients the practice held events in the waiting area. For example, the practice had planned for an awareness raising open day to be held in November 2018.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice showed good performance in relation to the low prescribing levels of some selected antibacterial drugs. When we discussed this with the practice they told us that the principal GP and pharmacist had close oversight of prescribing and that this was regularly discussed at clinical meetings.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice used these registers to deliver services such as learning disability health checks. Due to the complexity of these checks the practice allocated these as 30-minute appointments.
- Patients and their carers were offered consecutive appointments when required to avoid unnecessary waiting.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice worked closely with another provider who delivered specialist health support for adults who had learning disabilities and who had difficulties accessing mainstream health services, even when reasonable adjustments had been made.

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. The practice was able to refer patients in crisis, via a single point of contact number, to a specialist service who were then able to identify and support delivery of the most appropriate course of action to meet these specific needs.

Good

Are services effective?

- 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.
- Performance in relation to mental health conditions was either comparable to or better than local and national figures. For example,100% of patients diagnosed with dementia had their care plan reviewed in a face-to-face review in the preceding 12 months compared to a CCG average of 87% and a national average of 84%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.
- The practice had carried out a number of clinical audits in the past 12 months to assess performance and improvement. These included audits in relation to antibiotic prescribing, unlicensed medications and oral nutritional supplements.

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. However, it was noted that training records showed some inaccuracy. We discussed this with the practice who soon after the inspection sent us evidence that this had been rectified.
- 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. For example, the practice had supported a nurse to train to become an Advanced Nurse Practitioner.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. Staff told us that they felt supported by the practice and that they could discuss training needs at any time.
- 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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions and when coordinating healthcare for care home residents. They 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 may be vulnerable or who had 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.

Good

Are services effective?

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing 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.
- Staff from the practice were active in social prescribing and were able to refer and signpost patients through a local voluntary community service organisation.

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 providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was generally positive about the way staff treat people. Of three patients we spoke with on the day of inspection and one after the inspection, only one patient had negative comments to make regarding the services provided.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information. Staff told us how they often assisted patients whose first language was not English to understand key health and care information.
- Patient records were updated to contain details regarding specific access needs.
- The majority of Care Quality Commission comment cards we received on the day were positive about the service. A number of these specifically noted the caring and helpful attitude of staff.
- Overall the practice was either comparable with or slightly below local and national averages for caring, based on data from the national GP patient survey. For example, only 71% of respondents stated that the last time they had a general practice appointment the healthcare professional was good at treating them with care and concern, compared to a CCG average of 79% and a national average of 87%.
- We discussed areas of lower than average patient satisfaction within the national GP patient survey with the practice. They told us that they had examined the results carefully and took seriously the points raised. In response to this the practice had developed an action plan to improvement performance in relation to patient experience. This included:
  - Installation of a new telephone system in April 2018.
  - As part of a local GP Federation initiative patients were able to access extended evening appointments and weekend appointments.
  - Staff had received training to improve patient experience, to manage expectations and to better signpost patients to appropriate services.
  - A dedicated staff member was in post who dealt with engagement activities.
  - Raising awareness of the survey with patients via a pop-up board in the waiting area which it used to promote responses.
  - Supporting the completion of survey forms from patients whose first language was not English.
  - Working with the Patient Participation Group to engage with patients.

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 that 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, the practice noted specific patient needs and requirements on their care records.
- 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.
- The practice was comparable to other practices in relation to questions which related to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs. Accommodation was also provided for breastfeeding mothers and their infants.
- 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

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours. In addition, via working with others in the local GP Federation, patients were able to access evening and weekend appointments at three other practices in the locality.
- 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.

Older people:

- All patients over 75 years 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. Patients who were frail or vulnerable had priority to receive same day face to face or telephone consultations.
- The practice signposted patients to local community and voluntary sector organisations when it identified need.
- Electronic prescriptions were available to patients, and telephone prescription ordering was available for elderly patients when identified as a specific need.
- The practice engaged with the CCG commissioned MESH (Medicines Support at Home) service. This was a pharmacist led domiciliary medication review service for elderly and vulnerable patients.
- The practice offered services for patients closer to home. In-house services included spirometry, 24-hour blood pressure monitoring and electrocardiograms.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Patients with multiple conditions had these reviewed at one appointment when appropriate. In addition, consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local health professionals to discuss and manage the needs of patients with complex medical issues.
- The practice participated in the Bradford Breathing Better programme to support patients with breathing conditions such as Chronic Obstructive Pulmonary Disease.
- Diabetes prevalence and identification has increased since the introduction of diabetes screening in-house.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances, or who had missed arranged appointments.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment or telephone consultation.
- The practice had a room available for breastfeeding mothers and their babies.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice carried out diabetes screening of identified patients.
- The practice was part of a GP Federation, and through this patients were able to access extended hours services from 6pm to 9pm and at weekends 9am to 1pm. Via the alliance patients also had access to services such as physiotherapy assessments and endoscopy.

Good

Are services responsive to people's needs?

- The practice reminded patients of appoints via text messages.
- In an aim to ease winter pressures the practice had offered additional services over a bank holiday weekend in 2017/18.
- The practice hosted a welfare benefits advisor and a dietician.

People whose circumstances make them vulnerable:

- If patients were housebound or otherwise vulnerable, they could request repeat prescriptions via their chemist or appoint a named individual to do this.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode.
- Patients and their carers could access consecutive appointments if required to prevent unnecessary waiting.

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.
- Annual reviews were carried out with patients on the mental health register, and those diagnosed with dementia.
- The practice had recently begun to offer physical health checks for patients with a serious mental illness as part of a CCG initiative.
- The practice carried out opportunistic screening to identify patients with dementia.
- Clinical staff were able to refer patients who had suffered a mental health crisis for additional specialised support via a single point of access telephone number.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- After learning from a past complaint, patients who were late and missed their appointments were either seen later or were offered the opportunity to rebook for a more appropriate time.
- Appointment slots were kept open for the duty doctor to meet unexpected demand.
- The practice had generally performed in a manner that was either comparable to or below local and national averages for questions relating to access to care and treatment collected in January to March 2018 as part of the national GP patient survey. For example, 49% of respondents said it was easy to get through to someone at their GP practice on the phone compared to a CCG average of 56% and a national average of 70%.

We discussed this performance with the practice who explained to us that they had examined these results and had developed and implemented specific actions to improve this performance. This included the installation of a new telephone system in April 2018, new extended hours access, and the adoption of a care navigation approach whereby staff were trained to assess the needs of patients and to suggest more appropriate services e.g. via a pharmacy.

Due to the timing of these improvements evidence of the impacts of these actions had been limited, although a number of comment cards and interviews with patients during the inspection indicated that accessibility was not a major issue.

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. We saw that complaints had been discussed at practice meetings and actions had been taken to prevent recurrence. It was though noted that the practice did not record informal verbal complaints. When we discussed this with the practice they informed us that this would be implemented, as it was seen as an important aid to learning and improvement.

Good

Are services responsive to people's needs?

- The practice told us that it tried to engage with patients from the start of the complaint process. This was helped by the language skills many of the staff had.
- The practice had developed a patient charter which explained what patients could expect from the practice.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as Good for providing a well-led service.

Leadership capacity and capability

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

- The leadership team were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable, and this was confirmed by staff. 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 and succession planning.

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.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- Their strategic approach was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population. For example, the practice was aware of local needs in relation to conditions such as diabetes and hypertension and had developed enhanced services to meet this need.
- The practice monitored progress against delivery of their strategic approach and had effective performance management processes in place.

Culture

The practice demonstrated that it 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.
- The leadership team 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 saw that the practice had a positive and constructive view with regard to complaints and incidents and viewed them as learning and improvement opportunities.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally and felt they worked well with each other.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities, this included their roles in relation to safeguarding and infection prevention and control
- Practice leaders had established 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.

Good

Are services well-led?

- The practice had processes to manage current and future performance. Leaders and managers had oversight of safety alerts, incidents, and complaints and there was assurance that these were cascaded across both clinical and non-clinical staff as required.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. For example, we saw how clinical audit had been used to drive improvements in prescribing practice.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.
- On the day of inspection the practice and others in the locality had suffered a significant IT failure. We saw that this was effectively managed, and that the impact on patient care was minimised.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Team meeting minutes were kept and were available for reference on the shared practice IT drive.
- 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. For example, the practice had actively planned responses in respect to some below average patient satisfaction responses in the national GP patient survey.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A 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). Feedback from the PPG indicated that they worked well with the practice and that their views were respected
- 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.
- 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 amongst staff and used to make improvements.
- Leaders and managers encouraged and enabled staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.