Dr Arthur & Partners

Quality Report

Church Street Practice
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Outstanding
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Arthur and Partners on 26 October 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. This was shared with all staff who demonstrated a detailed knowledge of learning from previous events.
- Risks to patients were assessed and well managed through good emergency planning strategies and staff training. The practice was proactive in responding to risks outside of the building, such as in the provision of emergency grab bags for road accidents following a number of incidents.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment and this was regularly assessed with a programme of audits.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. A highly active patient participation group encouraged involvement from patients.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day and additional capacity provided by an emergency care practitioner.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.
- There was significant, seamless provision for patients at the end of their life through a robust palliative care programme. This included multidisciplinary team coordination, home visits, regular meetings and a review of every patient death to ensure every effort was made to ensure patients died in their preferred location. In addition, staff sent a bereavement support letter to carers on the first anniversary of a death with details of how to obtain extra support if needed.

We also saw areas of outstanding practice:

- Staff demonstrated consistent attention to detail and embed and maintain individualised care. This included a home visit to support a patient to use the online booking system and matching appointment times to the local bus timetable for patients who relied on it for transport.
- The practice proactively engaged with the local community to provide additional services and opportunities for patients. This included devising an introductory programme to primary care for students applying to university and opportunistic health checks offered in a local supermarket. The patient information group had successfully organised a health and wellbeing event that attracted 25 local services or organisations to help improve health promotion and reduce social isolation, which received praise from the town's mayor.
- The practice worked with the clinical commissioning group and community service providers to support homeless and refugee patients. This included providing staff with specialist safeguarding training and updating patient protection policies.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Outstanding 

The practice is rated as outstanding for providing safe services.

- Patients and staff were protected by a well established safety culture.
- There was an effective system in place for reporting and recording significant events, including quarterly review meetings and a supportive 'no blame' culture of working. Risks were well managed because staff reviewed practices constantly and whenever a 'near miss' was identified, immediate action was taken.
- Lessons were shared to make sure action was taken to improve safety in the practice and there was evidence all staff were included in this.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. This included up to date policies with guidance for staff on obtaining urgent specialist advice and safeguarding leads who were trained in identifying and responding to neglect and abuse.
- Emergency plans were robust, regularly tested and staff were appropriately trained in emergency preparedness and business continuity.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There was a holistic approach to assessing, planning and delivering care, including in the use of innovative approaches to care. Clinical audits demonstrated quality improvement and a proactive approach to conducting pilot schemes and changes in practice to maximise good patient outcomes
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average compared to the national average and in some cases significantly better.
- Staff assessed needs and delivered care in line with current evidence based guidance and this was assessed regularly

Summary of findings

through a programme of audits that demonstrated consistently good results. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. This was achieved through a comprehensive on-going training programme that supported staff to progress. There was evidence the senior team supported staff in continuing professional development and this improved services to patients. This included opportunities to participate in benchmarking and research.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs and this significantly contributed to the range of individual care options.
- The practice had a substantial long-term research profile with evidence this contributed to on-going improvements to patient care and quality measures. Two clinical research leads were in post and staff were encouraged to become involved in research within frameworks that protected patients from risk.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice highly for access to staff and their interactions with all members of the team. The practice performed similarly to or better than other local practices and the national average in most measures of patient satisfaction.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The patient involvement group was highly active and acted as patient advocates, regularly engaging with patients to gain feedback and ensure the practice met their needs.
- Information for patients about the services available was easy to understand and accessible in multiple formats, including large print and easy read.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

- Practice staff reviewed the needs of its local population and engaged with other local services to make sure individual care needs were met.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Staff provided weekly visits to two local care homes and were able to provide home visits and remote telemedicine care and treatment for patients with limited mobility.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders and the practice was proactive in engaging with patients and relatives about complaint investigations and outcomes.
- A private waiting room was available for patients in distress or who needed a private area for reasons such as infection control or breastfeeding.
- An emergency care practitioner, who was a trained paramedic, provided support for minor illness and injuries, triage and home visits.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy that was challenging and included rewarding staff for innovative practice and service development. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The leadership team had a shared purpose with staff at all levels and this contributed to a culture driven by evaluation and improvement.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. The provider was aware of and complied with the requirements of the duty of candour. The partners and managers encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient involvement group was active and had a track record of successful engagement

activities. Staff reported high levels of satisfaction and demonstrated clear and sustained pride in the organisation. Engagement with staff and patients was constructive and conducted in a way that valued challenge.

- Succession, sustainability planning and continuous learning and improvement were embedded into the working ethos of the practice and staff had a track record of participation in pilot schemes that were designed to enhance care and improve patient outcomes. This formed part of an overall culture of proactivity in which the practice sought new ways to serve its local population.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. Staff recognised the challenges of providing continuity of care to a population disproportionately represented by older people.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs, including rapid telephone triage where appropriate.
- Support was provided for carers and family members after a bereavement, including support to access counselling and a support letter on the first anniversary of a death.
- Scheduled weekly surgeries took place in local care homes and nursing homes and home visits were coordinated between GPs, district nurses and practice nurses.
- The emergency care practitioner offered a daily visiting service and was able to refer patients to a local emergency medical unit.
- GPs used a telemedicine system to liaise with secondary care providers for the management of ulcers amongst frail patients, which reduced the need for hospital attendance.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Practice nurse prescribers and supervised healthcare assistants had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- A nurse-led diabetic service was offered with insulin conversion support on a weekly basis. Nurses provided this service in accordance with the latest treatment advice, which they maintained through attendance at quarterly diabetes forums.
- Specialist practice nurses and trained healthcare assistants visited housebound patients with long term conditions.
- A recall system was in place to identify patients with multiple conditions or complex needs and worked to reduce the need for multiple attendances.
- Longer appointments and home visits were available when needed.

Summary of findings

- All patients with a long term condition had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, including children on a child protection register and adolescents who presented with intoxication or sexual health risks.
- Immunisation rates were high for all standard childhood immunisations and the practice performed at 100% for all childhood immunisations for those 12 months old or under. In addition, the uptake of the flu vaccine for children aged two to four years was significantly higher than the national average, at 78% compared to 34%.
- Patients provided good feedback about how well the practice managed the care of children and were positive about urgent and emergency care.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Flu clinics and asthma clinics were offered after school hours and on one Saturday morning per month in response to demand.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice demonstrated high uptake of adult immunisation programmes. For example, uptake of the teenage meningitis vaccines in 2015 was 61%, compared with the national average of 34%.
- The child safeguarding lead met formally with health visitors every three months and liaised proactively on a case by case basis.
- Reception staff were trained in ensuring teenagers had appropriate access to appointments for emergency contraception and the practice performed better than the national average for Chlamydia screening.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people.

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included early, late and Saturday appointments with healthcare assistants, nurses and GPs.
- The practice was proactive in offering online services as well as a full range of health promotion and online repeat prescription requests. In addition, patients who commuted for work were able to coordinate care and treatment in a way that suited them, including by e-mail and through the use of telemedicine.
- A nurse provided a triage service for travel vaccine requests and could provide travel clinics on-demand.
- The clinical skill mix covered a range of specialty areas, including women's health, ear, nose and throat and dermatology.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances make them vulnerable.

- The practice had policies for the care and treatment of patients living in vulnerable circumstances including homeless people, refugees and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and letters sent to patients with a learning disability were printed in a font and style of language each patient could understand.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations and the patient involvement group actively facilitated this.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice had registered refugee families and homeless patients and was able to provide individualised care based on their specific needs.
- The practice prioritised vulnerable patients and staff ensured they were seen if they attended without an appointment.
- Anticipatory care plans were used to provide care for patients at an increased risk of hospital admission or who were expected to need palliative care in the future.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health.

- 86% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84% and better than the clinical commissioning group average of 85%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia and proactively sought to improve care for patients through pilot schemes and research.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia and attended training specific to their role.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 and relate to responses between July 2015 to September 2015 and January 2016 to March 2016. The results showed the practice was performing significantly better than national averages. 237 survey forms were distributed and 115 were returned. This represented a response rate of 49%, which was better than the national average of 38%.

- 91% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 94% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 95% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 94% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

At the time of publishing our report, comparable data for the above measures were not available from the local clinical commissioning group.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 43 comment cards and all but one were positive about the standard of care received. Patients commented on high standards of continual care, treatment for long term conditions, a positive approach to sexual health and good coordination with other services.

Outstanding practice

- Staff demonstrated consistent attention to detail and embed and maintain individualised care. This included a home visit to support a patient to use the online booking system and matching appointment times to the local bus timetable for patients who relied on it for transport.
- The practice proactively engaged with the local community to provide additional services and opportunities for patients. This included devising an introductory programme to primary care for students applying to university and opportunistic health checks offered in a local supermarket. The patient information group had successfully organised a health and wellbeing event that attracted 25 local services or organisations to help improve health promotion and reduce social isolation, which received praise from the town's mayor.
- The practice worked with the clinical commissioning group and community service providers to support homeless and refugee patients. This included providing staff with specialist safeguarding training and updating patient protection policies.

Dr Arthur & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was supported by a GP specialist adviser.

Background to Dr Arthur & Partners

Dr Arthur and Partners is based at Church Street Practice, Wantage, Oxfordshire OX12 9BN. The practice has level access from the car park and to all treatment rooms. It has a clinical team of a senior partner, five GP partners, two salaried GPs, one registrar, one locum, an emergency care practitioner, a senior healthcare assistant (HCA), three HCAs, a nurse manager, an advanced nurse practitioner, nurse prescriber and three practice nurses. Seven doctors were female and three doctors were male. The non-clinical team consists of a practice manager, an information manager, a reception manager, a deputy reception manager, five receptionists, four prescription team administrators, a medical secretary and a finance assistant.

The practice is readily accessible for people who use wheelchairs and by parents with pushchairs. A portable hearing loop system is available and there are quiet waiting facilities for patients who find the main waiting area can cause anxiety. Private space is available for breast-feeding. Patients can check-in using a self-service kiosk, which provides instructions in several languages.

The practice services a patient list of 13,600 and is in an area of very low deprivation. Of the patient list, 52% are living with a long-term condition and 70% are in paid employment or full time education.

This is a teaching and training practice, including for foundation level and specialty trainee doctors, medical students from two universities and student nurses.

Appointments are from 8am to 8pm on Mondays and 8am to 6.30pm Tuesdays to Fridays. Appointments were available on one Saturday per month from 8am to 11am and late appointments were offered until 8pm on some Wednesdays. Out of hours patients were directed to use the NHS 111 service.

We had not previously carried out an inspection at this practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 October 2016.

During our visit we:

Detailed findings

- Spoke with GPs, nurses, healthcare assistants and a range of non-clinical staff and members of the patient information group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed personnel files, including induction and probationary reports.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Outstanding ☆

Are services safe?

Our findings

Patients and staff were protected by well established and effective safety systems and culture. Where openness and transparency encouraged learning when things went wrong.

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Between October 2015 and September 2016 the practice reported 42 signfiicant events. The whole practice team attended a quarterly review meeting of significant events and there was evidence that each individual was supported to contribute to changes in practice and policy to help avoid future incidents. For example, a member of staff used an expired vial for a smear test. This was noticed immediately and it was found the template staff used to record smears was incorrect. This was changed to include the batch number and expiry date of each vial to provent the problem happening again.
- There was evidence that following an incident, staff investigated this thoroughly and worked with other organisations to find solutions. For example, when a member of staff misinterpreted an allergy warning on the electronic patient records system, it was found the warning was the same colour as a number of other routine messages. The practice worked with the software developer and planned to join a national user group to inform future developments.
- Staff were confident in the system used to submit incident reports. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This formed part of a wider working culture that valued honesty and enabled staff to work on a 'no blame' basis, which encouraged them to report concerns or problems to the senior team.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. This included good standards of communication with relatives and carers when things went wrong and staff demonstrated they were able to adapt their communication to individual patient needs. For example, following a significant event that involved a patient with a learning disability, staff ensured they adapted their communication to make sure the patient fully understood the problem.
- Incidents were discussed at a weekly clinical meeting and the practice carried out a thorough analysis of significant events as part of a quarterly meeting. Learning was identified, documented and shared with all staff where appropriate.
- Learning that involved external staff or teams was identified and shared appropriately. For example, where a potential information governance breach was identified, the practice policy on confidentiality and data management was reiterated to all visiting staff and checks introduced to ensure compliance. In addition, where a pharmacy was found to supply a product with an imminent expiration date, the practice liaised with them to ensure products supplied had a more practical shelf life.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a safety alert about a patient injury from fast-closing fire doors, the practice assessed the fire system to ensure anyone moving through fire doors when they closed would not be injured by them. In another example, a new home visiting protocol was established to ensure staff could effectively prioritise those patients with the greatest need. This followed a patient safety alert following which the practice also checked for any incidents in which patient care may have been compromised or delayed because of how home visits were planned and conducted.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe. All staff were aware and understood their responsibilities in relation to patient safety.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly

outlined who to contact for further guidance if staff had concerns about a patient's welfare and were updated on a regular basis. There was a lead member of staff for adult safeguarding and for child safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff had undertaken additional training and multidisciplinary work to ensure they could safeguard homeless patients and those with refugee status.

- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the nurse manager were trained to child protection or child safeguarding level three. Training was comprehensive and included recognising neglect in disabled people, identifying fabricated and induced illness and responding to intoxicated adolescents.
- A robust child safeguarding policy was in place and had been updated in October 2016. This included information for staff on how to make rapid referrals to specialist children's teams, including for suspected sexual exploitation and female genital mutilation. Staff demonstrated knowledge of this in practice and used established relationships with other organisations to ensure concerns were escalated appropriately, including when caring for highly vulnerable people.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the 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. In addition, the practice manager maintained a log of DBS checks to ensure all staff had an appropriate level of clearance. Male GPs could act as chaperones for male patients and were also available responsively for men's health, including adolescent male sexual health. This provided an enhanced level of care in addition to the sexual health programme offered by nurses and enabled patients to have a choice of male or female staff.
- The practice maintained appropriate standards of cleanliness and hygiene through the use of cleaning standard checklists. This enabled cleaning staff to work to established guidance and maintain specific levels of infection control practice.
- We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- An annual infection control audit was undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, staff ensured water temperature checks were conducted by the property landlord, staff were provided with more comprehensive infection control and hand hygiene training and the practice introduced single use disposable instruments.
- Following recommendations from an annual infection control audit, the practice had adopted the aseptic non touch technique to minimise the risk of cross-infection in patients.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe including obtaining, prescribing, recording, handling, storing, security and disposal. A medicines management policy was available to staff and was in line with prescription protocols. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of local pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Three nurses had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role and supervision records we looked at indicated consistently good standards of practice. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

Are services safe?

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives.
- A fire risk assessment had taken place in February 2016 and weekly fire alarm tests and annual evacuation tests were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella, such as monthly water temperature checks. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant emergency alarm system on all computers that alerted staff to an emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had resuscitation equipment, including a defibrillator, available on the premises and oxygen with adult and children's masks. A member of staff conducted and documented a weekly safety check on this equipment. A first aid kit and accident book were available. All such equipment was managed in line according to an up to date emergency equipment protocol.
- In response to previous emergencies outside of the practice involving car accidents, the practice kept two emergency equipment bags that staff could use to treat injured people while waiting for an ambulance.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive disaster handling and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and contingency plans should the premises become uninhabitable. This included existing agreements with other providers who could accommodate practice activity in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. We looked at eight records and found risk assessments, care plans and prescription templates to be completed appropriately and in line with national guidance.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results from 2015/16 were 100% of the total number of points available. Exception reporting was significantly higher (10% or higher difference) than the clinical commissioning group (CCG) or national averages in the atrial fibrillation, depression and primary prevention of cardiovascular disease clinical domains. For atrial fibrillation, this was 21% compared to 11% nationally; 37% compared with 25% nationally and 43% compared with 30% nationally for the primary prevention of cardiovascular disease. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. We spoke with clinical staff about the relatively high areas of exception reporting and our specialist advisor reviewed practice data. We were satisified exception reporting was mitigated through processes that monitored patient outcomes and wellbeing, including follow-ups and reviews. The overall exception reporting average for 2014/15 was 11.4%. Data from 2015/16 showed a 0.3% decrease.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2014 to March 2015 showed:

- Performance for diabetes related indicators was better than the national average and CCG average in all five indicators. For example, 99% of patients with diabetes received a flu vaccine in the preceding 12 months, compared to the CCG average of 90% and the national average of 88%. In addition, 98% of patients with diabetes had a foot examination and risk classification in the preceding 12 months, compared with the CCG average of 90% and the national average of 88%.
- Performance for mental health related indicators was better than the national average and the CCG average in all three indicators. For example, 97% of patients with schizophrenia, bipolar affective disorder or other psychoses had an agreed, documented care plan in the preceding 12 months compared with the CCG average of 89% and the national average of 88%.

There was evidence of on-going, proactive quality improvement including clinical audit, including as a result of the ongoing review of NICE guidance :

- The clinical team reviewed the results of the National Review of Asthma Deaths and audited practice asthma reviews as a result. This audit led to staff working with patients to develop self-management plans and inhaler techniques.
- Following NICE guidance on recognising and referral, the practice reviewed all patients who had been diagnosed with colorectal cancer between March 2014 and March 2016. This audit found 17% of patients experienced a delayed presentation and diagnosis of cancer. As a result, GPs introduced routine rectal examinations for all patients who presented with symptoms and a policy that provided a structured waiting and assessment period for patients with suspected cancer symptoms.
- The practice participated in local audits, national benchmarking, accreditation and peer review. Audits indicated performance was better than the national average in the care of patients with atrial fibrillation, including 94% of patients treated with an anticoagulant or had a documented reason why this was not appropriate.
- There had been 20 clinical audits completed in the 12 months prior to our inspection and results were used to

improve practice and patient outcomes. For example, following an audit of uptake of pneumococcal vaccinations in patients over 55 years old, the practice improved the coeliac review invitation letter to encourage more patients to attend. This was to achieve the practice standard of 100% of patients with coeliac disease should have an x-ray for bone mineral density and 80% of patients with coeliac disease to have a pneumococcal vaccination. In October 2016, achievement against these standards was 70% and 55%, respectively and an education and re-audit plan was in process.

- Results of an audit to assess the use of antibiotics in patients with reduced kidney function who had a urinary tract infection indicated a good standard of practice. In this audit 99% of patients with reduced kidney function were treated with an antibiotic other than a product known to cause side effects, against a practice standard of 100%.

The practice used outcomes to identify and implement improvements. For example:

- Staff in the practice had a significant track record of engagement in research and this was managed by a principal research lead and a research nurse. Senior staff were proactive in developing the research skills of the practice team and six other clinical staff had taken part in research activity in the 12 months prior to our inspection.
- Research activity was wide-ranging and helped the practice to explore novel treatments and patient care. In the 12 months prior to our inspection, practice staff had been involved with 12 different studies and there was evidence research outcomes and involvement had improved patient care. Research participation was structured to ensure patient care and access to appointments was not affected and the practice was funded by the National Institute for Health Research, which enabled one GP session and two nurse sessions to be dedicated to research activity each week. Recently this had included pilot research into dementia care in the GP environment and a weight management study.
- In April 2016 the service introduced a telemedicine clinic for elderly patients with non-healing leg ulcers to help reduce hospital attendances. As part of the clinic the seven patients identified had a leg ulcer scan consultation and a follow-up telemedicine appointment with the consultant at the practice. This saved each patient a four-hour round trip to the hospital for the same treatment and each patient had a treatment plan implemented by an experienced nurse who had not responded to regular treatment and enabled them to receive faster consultant review.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment:

- The practice had a comprehensive, structured induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. This included time spent with a GP on home visits and work with multidisciplinary professionals for clinical staff. Several members of staff contributed to the induction programme, including the practice manager, information manager and infection control lead. This ensured new staff received comprehensive instruction and support.
- The practice could demonstrate how they ensured role-specific training and updates for relevant staff.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months. The practice recognised the continuing development of staff skills, competence and knowledge as integral to ensuring a high-quality service.
- The practice was proactive in supporting staff to increase and broaden their skills and ensuring this approach contributed to patient experience and the efficiency of the team. For example, a medical administrator was trained to assist with prescriptions and completed a trial of managing these. The trial

showed that 63% of letters did not need to be seen by a GP as they just needed filing. Following the trial the new system was implemented to maintain the improved administrative efficiency.

- The practice demonstrated consistent and on-going support to develop staff. For example, the three team leaders in post at the time of our inspection had been promoted internally following successful development. In addition, a nurse who joined the practice from a district nurse team was supported by the practice nurses and nurse prescribers to build their skills and competencies in-practice. The clinical team supported a healthcare assistant to achieve an assistant practitioner qualification. This included GP-led clinical competency training sessions.
- The nursing team demonstrated a commitment to ongoing professional and clinical development. For example, two nurses received support from the practice to become nurse prescribers and completed this course with distinction. Two nurses had undertaken clinical history training at Masters level, which enabled them to provide significant support to GPs.
- Following a successful pilot project, a GP and healthcare assistant undertook specialist dementia training and launched a service that enabled them to screen, diagnose and initiate dementia treatment and refer patients rapidly to secondary care services.
- An emergency care practitioner provided urgent care to patients both in the practice and on home visits. This member of staff was trained in emergency treatment and liaised with the ambulance service and secondary care providers to coordinate patient care.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. The electronic patient records system was connected with out of hours services and the emergency ambulance service, which enabled staff to quickly access up to date information to help them treat patients.
- The practice shared relevant information with other services in a timely way, for example when referring patients to secondary care.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.
- Clinical staff reviewed unplanned hospital admissions or readmissions every two weeks and followed up with the patients or the hospital as appropriate. GPs followed up with patients following discharge from hospital and updated their care plan. This was used effectively to ensure care and treatment was appropriate and timely. For example, one patient had been discharged from hospital too early and was readmitted with the support of their GP.
- Staff fostered proactive working with multidisciplinary teams when coordinating care for patients in vulnerable circumstances. For example, to ensure refugee families received the urgent care they needed, GPs established a confidential communication agreement with a translation service and worked with the British Red Cross and clinical commissioning group. In addition, multidisciplinary teams were established for specific patients, such as a pregnant homeless patient who needed access to community midwives as well as safeguarding crisis teams. Safeguarding policies had been adapted to include these groups and helped staff to provide specialised support in a structured framework.
- Staff were proactive in engaging with other healthcare services to improve their knowledge and practice. For example, nurses attended a regional forum on contraception updates and attended a quarterly diabetes nurse forum to ensure the practice met the regional weight management pathway. In addition the clinical team worked with colleagues in a neighbouring GP practice to attend lunchtime education meetings, such as with an implant lead.
- A GP lead for palliative care was in post and led a quarterly multidisciplinary review of all patient deaths. The practice manager, community matrons, Macmillan

nurses and district nurses also attended this meeting, which was used to identify if patients died in their choice of location and if anything could be improved in how palliative care was provided.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the MCA 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance, including with the Fraser guidelines and Gillick competencies.
- Staff conducted procedures only after receiving documented consent, which was obtained using forms specific to each case, such as a subdermal implant, an intrauterine device or undergoing minor surgery.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse established the patient's capacity using an MCA assessment and recorded the outcome.
- The process for seeking consent was monitored through patient records audits. The latest audit had taken place in August 2016 and the results were being analysed at the time of our visit.
- In April 2016 the practice included questions about consent in the patient survey, including whether patients understood the choices they had about whether their records were shared with health professionals outside of the practice. In response to the survey information on consent was provided at reception and on the practice website.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on weight management and their diet were provided with individualised support. Patients were signposted to relevant services such as a health and wellbeing centre and a care navigator role was in development to ensure patients had the most appropriate advice for their needs.
- Anticipatory care plans were used to help prevent hospital emergency admissions and to ensure patients who were likely to need palliative care received well-coordinated attention from the practice multidisciplinary team.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.
- The patient information group (PIG) worked with clinical staff to provide a diabetes peer support group for patients. The PIG demonstrated a proactive approach to engaging with other agencies, such as a recent information visit from Diabetes UK and planned visits from local pharmacists.

The practice's uptake for the cervical screening programme was 90%, which was better than CCG average of 73% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The uptake of breast cancer screening was 83% compared with a CCG average of 76% and national average of 73%. The uptake of bowel cancer screening was 60%, compared with a CCG and national average of 58%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to or better than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100%, with 100% immunisation for all infants up to 12 months old. Childhood immunisation rates for five year olds ranged from 94% to 99%.

- The practice demonstrated high uptake of immunisation programmes. For example, uptake of the teenage 'ACWY' meningitis vaccinations in 2015 was

Good

Are services effective?

(for example, treatment is effective)

61%, compared with the national average of 34%. In addition, the uptake of the flu vaccine for children aged two to four years was significantly higher than the national average, at 78% compared to 34%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice offered Saturday flu clinics that enabled patients to attend for a flu vaccination with minimal time needed in the practice. An after-school programme was available so schoolchildren could attend for their flu vaccination in the late afternoon or early evening.

The patient information group had worked with the practice manager and staff from another GP practice in the building to plan and run a health and wellbeing event. This included 25 stands from local service providers and community organisations to help improve health promotion and reduce social isolation amongst patients. For example, stands with specialist information on health conditions such as stroke and diabetes management were included and a local cycling club, singing club and walking club attended.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All but one of the 43 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. In particular, patients noted the friendliness of receptionists and said they appreciated the time clinical staff spent with them to discuss anxieties and worries.

We spoke with two members of the patient information group (PIG). They also told us they were satisfied with the care provided by the practice and said dignity and privacy was respected..

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

As part of the senior team's ethos of facilitating an open, honest and non-blame culture of work that supported improvement in practice and acknowledged good work, the significant event register included significant instances of positive feedback from patients. For example, one patient contacted staff to commend them on how they had approached a weight management problem.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

The practice's computer system alerted clinicians if a patient was also a carer. The practice had identified 442 patients as carers (3% of the practice list). Written information was available to direct carers to the various avenues of support available to them such as community support networks and a dedicated carers centre.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

Good

Are services caring?

The practice provided facilities to help patients be involved in decisions about their care:

- Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format as well as to order in Braille and large print. Staff were also able to organise for a British Sign Language interpreter or advocate to accompany patients to appointments. In addition, the patient information group was structured as an advocacy group for patients and proactively advertised themselves to patients, including through a rota system displayed in the waiting room.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website and staff were well informed of the availability of community support and advocacy services.

The practice's computer system alerted staff if a patient was also a carer. Written information was available to direct carers to the various avenues of support available to them as part of a dedicated support programme that included facilitating access to a carer's support fund for those in financial distress.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. In addition, staff sent a bereavement support letter to carers on the first anniversary of a death.

Staff provided an information advice line to carers to make sure they had something in place to obtain help or support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and ensured services were tailored appropriately:

- The practice offered flexible appointments for commuters, including through the use of telemedicine.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

· An emergency care practitioner supported GPs in providing patients who received end of life care or who were at high risk of hospital admission with an anticipatory care plan. This enabled the practice to provide responsive, well coordinated care to patients with urgent and complex needs.

- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice provided care and treatment that explicitly adhered to the Equality Act and ensured patients would not be discriminated against on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. This also included protection for people with complex needs, for example those living with dementia or those with a learning disability. Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice ensured patients who were homeless were able to register, access appointments and receive care that met their specific needs and circumstances. Staff achieved this by enabling secure e-mail contact between the patients, GPs and the safeguarding team as well as local midwives for a pregnant patient. Additionally, the practice ensured care was provided for refugee families that had moved into the area and acted as a link between primary and secondary care for them. Staff ensured patients were not disadvantaged because they were unable to provide a fixed address.
- The practice provided a minor injuries service for walk-in patients. This meant patients were never turned away without being reviewed and GPs ensured they had safe transport to alternative services if needed. GPs and nurses responded to incidents and accidents in the local vicinity of the health centre regardless of whether people involved were patients.
- Following the closure of a neighbouring practice, more space was made available for counsellors. This enabled more patients to access a counsellor and enabled GPs and counsellors to work together more closely.

Access to the service

Appointments are from 8am to 8pm on Mondays and 8am to 6.30pm Tuesdays to Fridays. Appointments were available two Saturdays per month from 8am to 11am and late appointments were offered until 8pm on some Wednesdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

The practice was preparing to offer asthma appointments for children during school holidays to improve uptake.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 88% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 91% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice had a system in place to assess:

- Whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Carers were offered appointment slots to meet their individual needs. For example, staff knew which carers attended the practice by bus and offered appointments to coincide with the bus timetable.

All reception staff were trained in a structured triage protocol that enabled them to safely identify when patients were in need for an urgent same-day appointment or when they should be referred to the ambulance service instead.

In 2016 the practice re-invested prescribing incentive monies along with practice funds to enable an extra consulting room to be created and furnished. This enabled clinicians to be able to see more patients.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. An annual complaints review took place with staff that included a discussion of trends in complaints as well as informal feedback from patients. Actions from complaint investigations were tracked and improved policies or work systems were introduced as result. This included a centralised monitoring system led by the practice manager and improved training for all staff on handling informal feedback and formal complaints. There was evidence staff tried to anticipate complaints and manage patient needs and expectations before a situation escalated to a formal stage. For example, if a member of staff felt an appointment could have been improved, they proactively contacted the patient concerned to discuss it.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system and this was proactively provided by staff whenever patients raised a concern.

We looked at 10 complaints received in the last 12 months and found in each case the complaints lead had conducted an investigation that included each member of staff involved and maintained contact with the complainant regularly. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, processes for issuing prescriptions were improved to ensure the patient was always involved in decisions and administration staff were provided with customer service training to help them manage challenging conversations. In each case complainants were offered a copy of the complaints procedure and encouraged to contact the appropriate ombudsman if they were unhappy with the outcome of the investigation.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This demonstrated that leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a five year business development plan that considered succession planning for staff who may plan on leaving or retiring, the continuation of the patient information group (PIG) and the development of the practice as part of an integrated health system. The practice also placed significant value on its training function and aimed to inspire new staff to enter primary care.
- Care was provided according to a practice charter that established 10 key elements of care standards patients could expect, along with a practice philosophy that outlined a commitment to excellence. This information was readily available in printed format in the waiting room and in electronic format on the practice website.
- The senior team was engaged in discussions with other local practices to strategise future developments to enable the practice to meet the needs of an expanding local population. This included plans to secure more facilities and scope the provision of joint primary and secondary care services.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality, performance and to make improvements, including through a well-structured system of weekly practice meetings.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They demonstrated how they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The practice operated a leadership system in which every member of the team was consulted on decision-making and had the opportunity to contribute to decision-making. The leadership team had an inspiring shared purpose that clearly contribute to the motivation of staff and their commitment to patient care and safety.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- The practice held weekly clinical meetings and quarterly whole-team meetings. Nurses and healthcare assistants (HCAs) held their own monthly meetings and other staff could join them where appropriate to discuss practice or case studies. Medical students were encouraged to attend meetings and present case reviews to other staff for feedback.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held annually.

Are services well-led?

Good

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

- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The senior team demonstrated a sustained, embedded structure of support for staff who wished to develop their skills.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service and welcomed challenge to improve standards.

- The practice had gathered feedback from patients through the PIG and through surveys and complaints received. The PIG met at least quarterly, actively encouraged patients to give feedback and submitted proposals for improvements and demonstrated a positive relationship with the wider practice team. For example, a GP and the practice manager attended each meeting and the PIG team ran a diabetes support group with help from clinical staff. This activity formed part of the PIG's embedded, integrative approach to engaging with patients and staff regardless of their role.
- Staff told us they felt involved and engaged to improve how the practice was run.
- The patient information group produced a quarterly newsletter that provided details of new clinics, updates about the practice and information on how patients could get involved. This included through submitting written feedback in a suggestion box in reception and by joining the group.
- GPs encouraged other practice staff to challenge and debate decision-making and planning as part of an open ethos of work.

Continuous improvement

- There was a focus on continuous learning and improvement at all levels within the practice. This included accountability for project leaders and the senior team acknowledged and rewarded innovative practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area, including involvement in the DROPLET weight management study. This study considered whether obese patients referred by GPs to a low-energy total diet replacement programme helped them to lose weight more than a weight loss programme led by a practice nurse.
- Nurses had taken part in a pilot study that looked at dementia awareness and care in GP practices. This included providing an enhanced service for patients over 65 years old and their relatives, such as provided memory screening and proactively speaking with people about the early warning signs of dementia and memory loss. Patients with a learning disability were included in this study, which helped staff to identify how dementia training could be improved.
- There was a clear drive to engage with people in the local community and to establish the practice as a centre for health and wellbeing above and beyond the clinical care of patients. For example, staff had developed an introductory programme to primary care for two college students who were preparing to apply to university. This gave the students insight into how GP practices worked and enabled them to spend time with staff to discuss how they could enter primary care in the future. This activity contributed to the practice's future sustainability plan and was carefully managed, with health and safety and confidentiality policies in place.