St Leonard's Practice

Inspection report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Good** ●
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as outstanding overall. (The previous inspection was in July 2015 – when the practice was rated outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at St Leonard's practice on 12 June 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 there was a genuinely open culture in which all safety concerns raised by staff and people who use services were used as opportunities for learning and improvement.
- 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.
- Patients said the care and treatment they received was very good and added that staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice was organised, efficient, had effective governance processes and a culture which was embedded effectively and used to drive and improve the delivery of high-quality person-centred care.
- The involvement of other organisations, voluntary services and the local community were integral to how services were planned and ensured that services met patient's needs.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care and were clear, supportive and encouraged creativity.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The practice was an active National Institute Healthcare Research (NIHR) centre.

We saw areas of outstanding practice:

- There was a culture of learning and education at the practice and staff had obtained further education including master degrees, doctorates and had other roles including professorships, university sub deans and clinical leadership roles. Three of the GPs had been awarded the bronze Clinical Excellence Awards, by the Advisory Committee on Clinical Excellence Awards (ACCEA). One of the GPs was recognised in particular for the educational innovations carried out at the practice that had been subsequently used in national and international contexts.
- The practice had an in house research team and undertook its own original research which influenced policy and educational curriculum changes at both local and national level. This included improving patient care and outcomes, reducing unexpected hospital admissions, improving education and improving the management of long term conditions.

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

Population group ratings

Older people	Outstanding ☆
People with long-term conditions	Outstanding ☆
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.

Background to St Leonard's Practice

St Leonard's practice is situated in the city centre of Exeter, Devon. The practice is located at:

St Leonard's Practice

Athelstan Road

Exeter EX1 1SB

The deprivation decile rating for this area is six (with one being the most deprived and 10 being the least deprived). The practice provides a primary medical service to approximately 9,300 patients of a diverse age group. The 2011 census data showed that the majority of the local population identified themselves as being White British.

There is a team of six GP partners and two salaried GPs providing 40 sessions per week. The GP team are supported by a practice manager (business manager), data manager, office manager, nurse practitioner, four practice nurses, three healthcare assistants (HCAs), and 14 administration staff.

Patients using the practice also have access to an independent on site pharmacy, health visitors, community nurses, mental health practitioners, osteopaths, midwives and community groups. Health care professionals visited the practice on a regular basis.

The practice is open from 8.15am to 7pm on Mondays and between 8.15 and 6pm on Tuesdays to Friday with a lunchtime closure on Wednesday between 1pm and 2pm. Appointments are offered between those times. Outside of these times patients are directed to contact the out of hour's service and the NHS 111 number in line with local contract arrangements. Extended hours are offered on six Saturdays per year and patients also have access to out of hours services locally

The practice offers a range of appointment types including face to face same day appointments, telephone consultations and advance appointments (six weeks in advance) as well as online services such as repeat prescriptions.

St Leonard's practice is an accredited training practice for post graduate doctors and medical students and is an established, internationally recognised research practice providing data that impacted on clinical practice and education.

This report relates to the regulatory activities provided by the practice;

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorders or injury.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians and reception staff knew how to identify and manage patients with severe infections including sepsis. Information and guidance was available to staff and patients were also provided with information on the TV screens in the practice waiting room and on the practice Facebook page.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- 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 which staff followed.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The practice had systems in place 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 had taken action to support good antimicrobial stewardship in line with local and national guidance. For example, GPs were aware that figures for certain antibiotic prescribing were above CCG and national levels. GPs explained that this was following local consultant microbiologist advice due to a local resistant strain of a particular bacterial infection (strep A).
- There were effective protocols for verifying the identity of patients during all consultations.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

Good

Are services safe?

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed 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.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology and equipment to improve treatment and to support patients' independence. This included a health pod at reception where patients could record their own blood pressure prior to their GP appointment, a practice website, practice social media pages on Facebook, computerised clinical templates and a practice intranet. These systems assisted the delivery of effective, accurate and up to date care and treatment and kept patients informed.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice used a named GP approach to care for patients to promote continuity as recent research they were involved in demonstrated considerable benefit of this approach.
- Regular complex care meetings included a focus on older patients who were frail or vulnerable. The practice used an appropriate risk tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of their medicines.
- The practice used a computerised patient record template which enabled an integrated approach for information sharing with other agencies, including out of hours and emergency services, to support older people. This included treatment escalation plans, future care planning and next of kin and carer recording.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice operated a named GP approach to care to provide patients with continuity of care.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. There were discrepancies with the data available to the inspection team and the practice. Practice data and data seen on public websites showed that uptake rates for the vaccines given were in line with the target percentage of 90% or above. However, data obtained

from NHS England showed the uptake rates ranged between 42% and 79%. The practice staff were looking into this discrepancy with NHSE, with a view to having the data rectified.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 73%, which was in line with the national downward trend in uptake (73%) but lower than the 81% coverage target for the national screening programme. We saw processes in place to follow up missed appointments, anecdotal evidence indicated an improving trajectory.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. This included involvement with social prescribing projects, National Institute of Research projects and In house research projects which contributed to locl changes locally and nationally. For example, changes to local care pathways locally and national changes to educational curriculums and care of patients with diabetes nationally.

- 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 monitored QOF targets and exception reporting rates. Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. For this period the practice had obtained 555 points out of 559 available and recognised the overall exception reporting rate was slightly higher than national and local averages. For example, 10% compared to local averages of 7% and national averages of 6%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

To understand the higher than average exception reporting rates we looked at patient records, spoke with staff and

identified a lower compliance rate and high rate of declined services. For example, the GPs monitored the asthma exceptions to ensure they were all patients that had been excepted following the practice protocols.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring and supervision and support for revalidation. The practice informed us that the appraisal programme had not been completed for this year but added that dates were booked. Staff said they received sufficient support on a day to day basis and informally as required. Staff added that there was a mutual sense of support at the practice and said all line managers and GPs were approachable.
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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. Staff said there was a culture of learning and education at the practice and they were encouraged to develop within their roles. There were four staff with master degrees, one had obtained a doctorate and other roles included professorships, university sub deans and clinical leadership roles. For example,

- One of the recently retired GPs (a professor) who was still working at the practice on the research team was an MPhil (advanced research degree with the prerequisites required for a Master of Philosophy degree) awarded by the University of Exeter and completed this whilst he was a full-time general practitioner at St Leonard's Practice. It is entitled 'Hyperlipidaemia in General Practice'. The thesis was written using data from the practice database. A number of publications arose from this including research articles in the British Medical Journal (BMJ) and Social Science & Medicine (SSM) journal, an Occasional Paper produced by the Royal College of GPs (RCGP) and publicity on BBC news websites.
- Another GP (a professor) was awarded a Masters in Medical Education in 2006 based on research carried out at the practice and with local Exeter GPs. The research investigated how GPs deal with having medical students for the first time. As a result of this work the GP negotiated improved pay rates for all GPs in Devon and Cornwall for teaching medical students.
- The practice undertook both National Institute Healthcare Research (NIHR) and the practices' own original research which influenced policy and educational curriculum changes at both local and national level.

The research team informed us that the research at the practice had attracted medical students to the practice and as a result had prompted them to look at being a GP as a career.

Two of the GPs were 'GPwSI' (GPs with a special interest) in dermatology and other GPs had special interests in women's health and diabetes. This had a positive impact on referrals. For example, the practice referral rates for dermatology in 2017/18 was nine per 1000 patients compared to the locality average of 10 per 1000 patients.

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 deciding care delivery for people with long term conditions and when

coordinating healthcare for care home residents. The practice staff shared information with, and liaised with, community services, social services, carers and with health visitors and community services.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their 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.
- The practice had worked with two nearby GP practices to set up a walking group. The city walks were open to all patients for the benefit of their health and wellbeing.

Consent to care and treatment

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

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

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure 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, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

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

The practice was rated as outstanding for responsive services because:

Research conducted at the practice had resulted in local and national changes. For example,

- The Practice led a unique research collaboration with the New Devon CCG. This achieved a publication in the Journal of Public Health describing the CCG's Devon Predictive Model, which performed well in predicting emergency hospital admissions. The longer time a patient was registered with a GP was found to be a new statistically significant factor associated with lower admissions. The tool enabled practices to identify and discuss these patients with the wider multidisciplinary team to agree a plan to reduce the risk of unplanned admissions.
- The practice used in house research to provide data driven care for patients with long term conditions (diabetes).The practice research lead had produced a paper (Improving continuity: The Clinical challenge). The study involved collaboration between St Leonard's Practice in Exeter and the university and was the first ever systematic review of continuity of care and mortality, and it found that the human aspect of medical practice was potentially life-saving and should be prioritised. The study, published in the BMJ Open and highlighted on BBC news sites.
- The provider had promptly and successfully responded to negative patient feedback about the telephone and appointment system.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- 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 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 operated a 'buddy' system between partners for continuity of care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- Patients with a long-term condition had a named GP
- Patients received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- One of the GPs offered enhanced cancer care support

The practice used in house research to provide data driven care for patients with long term conditions. For example, the practice employed a PhD research employee who worked with three other research staff including a recently retired GP from the practice. Recent studies had resulted in a new national programme for diabetes prevention in response to research carried out at the practice. This included:

- Research and published papers into diagnosing type two diabetes before patients complained of symptoms. Patients locally benefitted directly from this research through early diagnosis and treatment or health education.

Are services responsive to people's needs?

- Published papers on pre- diabetes and the cost of diagnosing type 2 diabetes mellitus by clinical opportunistic screening in general practice. It was identified that two thirds of patients could be detected before symptoms were reported offering an argument for affordable alternative for population screening. The paper was published in a diabetes UK magazine which had a national and international audience.

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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice used templates to record child protection information to ensure all information was gathered.

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

- A full range of contraceptive services including coil fitting was available at the practice. Two of the GPs had a special interest in women's health.
- 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, telephone consultations were in place.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

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.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice had 74 patients diagnosed with personality disorders which was higher than other local GP practices in the area (average of 40 of comparable sized practices). The GPs had set up a bespoke management plan for these patients.

Timely access to care and treatment

The practice had identified a 40% increase in demand for appointments in the last three years. The practice had responded with short term responses to demand to ensure patients continued to be able to access care and treatment from the practice within an acceptable timescale for their needs. This included:

- Protecting appointments to ensure same day appointments could be generated,
- Use of locum GPs
- Changes to administration sessions.
- Online prescribing, appointment booking and an increased use of the community pharmacist had been promoted.

The work and quality projects (productive general practice) had also resulted in changes to the organisation of workflow in the practice and to access.

In addition the research and publications made by the partners of this practice had a significant influence to their own practice and those nationally. The studies had resulted in changes to the provision of care. For example:

- Changes to consultation length of appointment system to be 15 minutes as standard
- A named patient list to achieve better continuity of care. The practice research lead had produced a paper in 2016 (Improving continuity: The Clinical challenge) which identified that continuity had benefits for patients and reduced risks and was a central feature of high quality general practice. A more recent paper (Continuity of care with doctors- a matter of life or death) which had recently been published and discussed on BBC newsites suggested that better continuity of care reduced death rates.
- Monitoring of patient list size, face to face appointments with named GP.

Outstanding ☆

Are services responsive to people's needs?

- Allocation of routine, non-clinical correspondence to administrators rather than clinicians

The practice had received negative feedback from patients about access to the telephone system and appointments. As a result:

- The appointment system was reviewed and changed to improve availability to patients.
- a wider internal survey was taken regarding this and improvements made to the telephone system.

Feedback form patients about access to appointments was positive.

- 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.

Feedback from staff had also influenced changes in the appointment system and had resulted in the 'on the day' team (GP, nurse practitioner and administration support) operating from the same location within the building. This had resulted in more effective communication and less interruptions.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

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

The practice was rated as outstanding for well led because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Research was embedded within the culture of the practice and seen as a way to evidence, improve and change their own patient care and to also influence local, national and international change through publication of many papers in international and national health care journals.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture and morale. There were consistently high levels of constructive staff and patient engagement.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There was strong collaboration and support across all staff teams and a common focus on improving quality of care and people's experiences.
- The GP partners had made a conscious decision to ensure patients had a named GP and appointment times were kept at suitable lengths to ensure 'quality' patient care could be provided.
- Staff said they felt well led and part of a team.
- The practice manager and GP partners 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. Staff said the practice manager was visible and approachable and provided encouragement and support. Leaders worked closely with staff and others to make sure the team prioritised compassionate and inclusive leadership.
- Staff met daily to discuss any issues or complex cases and to offer and receive peer support.

Vision and strategy

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

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

Culture

The culture developed at the practice was used to drive and improve the delivery of high-quality person-centred care.

- There were high levels of staff satisfaction. There were consistently high levels of constructive staff engagement and were actively encouraged to raise concerns. Staff said they were happy and the organisation was a good place to work. Staff said the leadership inspired them to deliver the best care and motivate them to succeed.
- The practice focused on the needs of patients. Staff feedback and suggestions focussed quality projects of how to make the processes more streamlined and efficient and improved care for patients. For example, two projects had led to changes in working patterns.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff said there was support given when things went wrong and were involved in the investigations.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Outstanding ☆

Are services well-led?

- 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. Staff said they received informal support when the required and could request learning and development at any time. 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. Staff said their colleagues and leaders supported them both professionally and personally.
- The practice actively promoted equality and diversity. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- Communication was effective at the practice and organised through structured, minuted meetings. These included partner meetings, clinical meetings, staff meetings, multidisciplinary team meetings, patient participation group meetings, nurses meetings, administration team meetings, notifications on the computer system and an open door policy used by the GPs and practice manager.
- Patients also received a newsletter with updates on practice news, out of hours information, health promotion and staff changes.

Governance arrangements

There were clear lines of accountability, responsibilities, roles and systems to support the embedded governance and management systems.

- Structures, processes and systems to support good governance and management were clearly set out, embedded, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safe medicines management, 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.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Outstanding ☆

Are services well-led?

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.

The practice had a well-established virtual patient participation group (PPG) group. There were 200 virtual members and 5 committee members. The leadership team valued the input from the PPG. The PPG worked with two other local PPGs to combine resources. As a result, patients could access art projects and health education events.

The PPG said they had had been involved in many aspects of the practice. These included input in feedback about the telephone system, suggesting a water cooler for the waiting room and providing health talks for patients.

There were consistently high levels of constructive staff engagement. For example, staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered. feedback from staff had resulted in two quality projects of the productive general practice programme being completed:

- Team planning project was as a result of staff frustrations with lack of clarity, insufficient GP sessions and staff stress. The outcome included a new annual leave policy, use of appointment templates, more GP sessions and new message formats.
- Emails, meetings and interruptions project came as a result of duplication of work, inefficiencies, interruptions and time pressures. The outcome included comparing agenda formats to reduce duplication, reducing the meeting frequency, agreeing ground rules and keeping to times in meetings.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

There was a focus on continuous learning and improvement within the practice. For example, in addition to being a successful centre for the recruitment to national research studies, the practice has been at the forefront of research in primary care- and continues this. One of the GPs was the national lead for research in primary care. The work, research and publications made by the partners of this practice were of huge influence to their own practice, resulting in changes to provision of care as well as influencing practice nationally and internationally.

The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.