Dr P A A Wood and Partners

Quality Report

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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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 P A A Wood and Partners on 28 June 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. All opportunities for learning from internal and external incidents were maximised and shared within the practice and the locality.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example; The practice had worked with four other practices in the locality to implement and fund a community based service that enabled direct referrals for patients with gynaecology, musculoskeletal problems and diabetes to receive assessment and care by a consultant in their community instead of travelling to hospital. Patients were usually seen by a consultant within three weeks of referral and had undergone the relevant tests in preparation for their initial appointment. The core principles of the initiative was to provide a more cost effective service which was also more responsive in terms of speed of assessment and treatment for patients.
- The practice actively reviewed complaints for trends and how they were managed and responded to, and made improvements as a result.
- Risks to patients were assessed and well managed.
- The practice regularly reviewed policies and made changes to practice based on audits and updates.
- 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.
- Feedback from patients about their care was consistently positive and data from the GP patient

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survey was consistently high. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had strong and visible clinical and managerial leadership and governance arrangements, and staff told us that they were well-supported and felt valued by the partners.
- The practice's senior partner used his leadership role within the CCG to keep the practice informed of new developments and opportunities

We saw several areas of outstanding practice:

- There was a practice initiative whereby the practice had developed an enhanced package of care for residential and care homes aligned to them which had resulted in a 9.1% reduction in visits to A/E department and a reduction of 22% in unplanned admissions to hospital in the preceding 12 months. This was funded by the practice.
- The practice had worked collaboratively with four local practices to implement a direct referral service so that patients could be seen by a consultant more quickly in their locality rather than travelling to hospital. This was initially funded independently by the practices and is currently being commissioned by the CCG on an ongoing basis and extended to a further seven practices locally.
- The practice actively contacted patients who did not attend for their cervical screening test and where patients did not respond to the third letter, a face to face appointment was made with the practice nurse to discuss their decision. This provided an opportunity to allay patients' anxiety and provide additional information to help them make their decision. This resulted in an uptake for the cervical screening programme of 91% which was 10% higher than the CCG and national averages Exception reporting for this indicator at 2% was lower than both the CCG and national averages.
- The practice actively followed up patients who did not attend their hospital breast screening appointment by sending a letter to the patient advising of the importance of the test and providing them with the hospital telephone number and their breast screening number so that they could more easily make a new appointment. This had resulted in achieved an attendance rate of 85% for breast cancer screening which was 7% higher than the CCG average and 13% higher than the national average.

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events, and lessons learned were shared throughout the practice at regular meetings. Learning was also shared with other practices in their locality. When there were unintended or unexpected safety incidents, patients received a verbal and 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 and staff had received training relevant to their role. The practice had conducted an audit on their management of safeguarding concerns and found that staff complied with policy and guidelines and were well informed about all aspects of safeguarding
- Risks to patients were assessed and well managed. Infection prevention and control procedures were completed to a satisfactory standard. There were effective systems in place to manage safety alerts, including medicines alerts which were acted upon.
- There was a robust process for managing incoming mail including test results which were acted upon on the same day if required.
- There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and clinicians used these as part of their work.

- Audits and reviews were undertaken and improvements were made to enhance patient care. For example; an audit relating to medicines conducted over three cycles showed that new guidelines were being adhered to.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included

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assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

- There was evidence of appraisals and personal development plans for staff. Most staff had received an appraisal in the preceding 12 months, and those remaining were scheduled for July. The appraisal process had recently been updated to enable more comprehensive appraisal discussions and development plans for staff.
- Staff worked closely with multidisciplinary teams to plan, monitor and deliver appropriate care for patients. The teams included midwives, health visitors, the community matron, district nurses and the mental health team.
- The practice worked very closely with eight residential and care homes aligned to them and had developed a package of care that included regular structured ward rounds, dedicated time for direct telephone access to a GP daily, and regular communication with relatives. This had resulted in a significant reduction in the number of patients being admitted to hospital from the residential or care home. This had also enabled 99% of these patients receiving end of life care to die in their preferred place.
- The practice had enabled direct referrals for gynaecology, musculoskeletal problems and complex diabetes and receive care in their community instead of travelling to hospital. This meant that patients were seen by a consultant within three weeks of referral and had undergone the relevant tests in preparation for their initial appointment.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. They had achieved 96% of their available points compared to the CCG average of 97% and the national average of 94.8%.

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 higher than others for several aspects of care. For example 92% of patient described their overall experience of the practice as good or fairly good. This was 6% higher than the CCG average and 7% higher than the national average.

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- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was a carers champion and a carers policy that outlined how all clinical staff were to identify patients who may be carers opportunistically, whenever patients attended for an appointment. This had resulted in registering 2.6% of their practice list as carers. These were then signposted to various support resources with help from the carers champion and the care coordinator.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- They were aware of the practice population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example; by providing an enhanced package of care for patients in residential and care homes; by recruiting a GP specially to look after the 260 patients in care homes; by recruiting an additional nurse to treat patients with chronic illness and to receive specialist training in this area to enable a nurse to treat patients with chronic illness in their own homes; and by enabling direct referrals for patients to see a consultant quickly within their locality rather than travelling to hospital.
- Patients told us they were satisfied with the appointment system and said they found it easy to make a routine appointment which was usually available the next day. Urgent appointments were always available the same day. Telephone consultations and home visits were also available.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The premises were suitable for patients who were disabled and there were baby changing facilities.
- 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 annual complaints meetings were held to reflect on learning from the preceding year and to ensure that any changes to practice had been embedded.

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Are services well-led?

Good

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

- There was a clear vision and strategy which was shared with staff who were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles. There were systems in place to monitor and improve quality and identify risk.
- The practice had a succession plan to address future needs when existing staff may retire which enabled staff to develop into potential roles for the future.
- The practice had developed a number of flexible roles that increased capacity and skill mix within the workforce and enabled personal development for staff. This meant that staff were able to perform a number of different roles and were able to step into another role when required to avoid interruptions to services due to sickness.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was working with the practice to develop this role.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- Staff gave examples of how the practice had provided support for staff during times of personal and health difficulties. Staff also told us about social events and charity events organised by the practice.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff and appropriate action was taken

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 serves a population that is much higher than average for older people and looks after 260 patients living in local care homes. The practice has 13.2% of patients who are aged 75 or over, which is ranked as the highest in the CCG. They also have 4.7% of their practice list who are aged over 85 years, which is also ranked as the highest in the CCG.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. All patients over 75 had a named GP
- Each of the eight residential and care homes aligned to the practice had a named GP who visited each home for one morning or afternoon session each month to plan care, conduct medication reviews, meet with patients, relatives and staff. The GP also made shorter weekly visits and urgent visits on the day when required. The practice scheduled dedicated time each day for residential and care home staff to speak to a GP for telephone advice. This had resulted in a 9.1% reduction in visits to the A/E department and a reduction of 22% in unplanned admissions to hospital in the preceding 12 months. The practice were proud of their relationships with the patients, relatives and care teams. Feedback from two care homes we spoke with was extremely positive about the care and service provided to residents and regarding the communication with relatives and staff.
- The practice had coordinated educational events for residential and care home staff to enable staff to develop their understanding of end of life care and to enhance relationships between the practice and care home staff.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs, including those patients in nursing and residential care.
- There were 2.3% of their older population who had care plans with the aim of enabling appropriate out-of-hours care, and ensuring that patients' expressed needs were met
- There was a proactive process for providing Influenza vaccinations and this included providing flu clinics on Saturday

mornings and in peoples own homes if they were housebound. There was a dedicated administrator who contacted all eligible people by telephone to arrange appointments and chase people who had not attended a planned clinic.
- The practice utilised a care coordinator to work with the named GP and community support team to facilitate care and respond to patients needs following discharge from hospital. Monthly multi-disciplinary team meetings were held to discuss and plan ongoing care.
- Services such as phlebotomy, hearing aid services and citizens advice were available on site for older patients

People with long term conditions

Good

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

- The practice had a higher than average prevalence of some long term conditions.
- Nursing staff had received advanced training in the management of long term conditions and had lead roles in chronic disease management. Further training was planned for one of the nursing staff to provide management of chronic diseases in patients own homes for housebound patients
- Future care planning was prioritised for patients at risk of hospital admission. All these patients had a named GP and were offered 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.
- The practice worked closely with the CCG pharmacist to ensure appropriate prescribing practice.
- There was rapid direct access to specialist nurse and consultant diabetes services for patients with complex care needs.
- The practice were in line with local and national averages for achievement in QOF indicators relating to diabetes. For example; 95% of patients with diabetes had received an influenza vaccination which was the same as both CCG and national averages.
- Longer appointments and home visits were available when needed. The practice had a high home visiting rate of between 10 and 20 visits per day, and provided early visits to ensure that those patients who were potentially the sickest were seen early for timely treatment or admission. The aim was to improve the

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patients' journey and improve outcomes for patients by treating early to avoid unnecessary hospital admission. This had resulted in an overall A/E admission rate that was lower than the CCG average.

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, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were higher than average for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- There were GPs who had specialist training and knowledge in family planning services, coil and contraceptive implant fitting. The practice also had access to a community based gynaecology service for advice when required. This meant that patients could attend an appointment with a consultant gynaecologist in their community within three weeks of referral and the relevant tests were arranged beforehand so that results were available on the initial appointment with the consultant.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- There was a midwife aligned to the practice and we saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice had Fraser and Gillick competence assessments embedded into the computer system to ensure that young people were actively encouraged to be involved in their care. A survey conducted by the practice identified that teenage patients felt that they were being provided with a service that met their needs.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working-age people (including those recently retired and students).

- 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 access to telephone consultations and on-line appointment booking services.

- The practice offered GP appointments throughout the day, including lunchtime, and extended hours clinics were available for two evenings and on Saturday mornings each week for working patients who could not attend during the day. Patients were also able to ask advice via email.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had provided a cervical screening test for 91% of eligible women in the preceding five years, which was around 10% better than the CCG and national averages.
- The practice used electronic prescribing and patients could request repeat prescriptions online.
- The practice utilised a community based provider that enabled patients to be seen by a consultant for gynaecology, musculoskeletal problems and diabetes in the community instead of at hospital, within three weeks of referral.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They had 49 patients on their register.
- The practice offered longer appointments for patients with a learning disability and an annual health review with a GP who had a special interest in learning disability. A GP had recently left the practice who had a lead role in managing patients with a learning disability. The practice had provided additional training for the new GP lead and also the administration lead and the health care assistant who would both be involved in treating or speaking with patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff received appropriate safeguarding training and knew how to recognise signs of abuse in vulnerable adults and children.

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They 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 recognised the needs of carers and provided them with a named GP and a health care assistant (HCA) who was a designated carers champion to assist in signposting them to the local resources for support.

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 (including people with dementia).

- The practice had established excellent collaborative working relationships with a local specialist unit for patients with dementia and other homes with a high proportion of patients with dementia. They had arranged for joint educational sessions for their aligned nursing homes with a psychiatry consultant guest speaker. Care home managers we spoke with confirmed that the events were useful and informative, and also provided an opportunity to build relationships with other care home staff and the practice staff.
- 78% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG and national averages
- All indicators relating to mental health were comparable to CCG and national averages.
- They held a register of patients who had a mental health problem and offered them an annual health review. They had provided a health review for 76% of patients on their register in the preceding 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia.
- The practice worked closely with adult and older adult psychiatry services and were able to refer patients with mental health problems to psychological therapy services
- They had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- 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, and utilised a care coordinator to assist with timely planning of care and to discuss any unmet needs.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

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What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing above local and national averages. A total of 243 survey forms were distributed and 109 were returned. This represented a 49% response rate.

- 84% of patients found it easy to get through to this practice by phone compared to the CCG average of 74% and the national average of 73%.
- 96% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 86% and the national average of 85%.
- 92% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 96% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards which were almost all positive about the standard of care received. Patients praised clinical staff for their caring approach and said they felt properly listened to.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, two patients said that they had to wait up to three weeks to see their preferred GP, but that other GPs were available

Outstanding practice

We saw several areas of outstanding practice;

- There was a practice initiative whereby the practice had developed an enhanced package of care for residential and care homes aligned to them which had resulted in a 9.1% reduction in visits to A/E department and a reduction of 22% in unplanned admissions to hospital in the preceding 12 months. This was funded by the practice.
- The practice had worked collaboratively with four local practices to implement a direct referral service so that patients could be seen by a consultant more quickly in their locality rather than travelling to hospital. This was initially funded independently by the practices and is currently being commissioned by the CCG on an ongoing basis and extended to a further seven practices locally.
- The practice actively contacted patients who did not attend for their cervical screening test and where patients did not respond to the third letter, a face to face appointment was made with the practice nurse to discuss their decision. This provided an opportunity to allay patients' anxiety and provide additional information to help them make their decision. This resulted in an uptake for the cervical screening programme of 91% which was 10% higher than the CCG and national averages Exception reporting for this indicator at 2% was lower than both the CCG and national averages.
- The practice actively followed up patients who did not attend their hospital breast screening appointment by sending a letter to the patient advising of the importance of the test and providing them with the hospital telephone number and their breast screening number so that they could more easily make a new appointment. This had resulted in achieved an attendance rate of 85% for breast cancer screening which was 7% higher than the CCG average and 13% higher than the national average.

Dr P A A Wood and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience.

Background to Dr P A A Wood and Partners

Dr P A A Wood and Partners is located in the village of Allestree which is a suburb of North Derby. The practice provides health care to the local community from two practice sites. Park Farm Medical Centre is the main practice, which is situated on the edge of the Park Farm shopping centre, and Vernon Street Surgery which is the Branch practice. This is a refurbished Georgian building situated in a city centre conservation area near Friargate.

The practice provides medical services to 11,582 patients under a General Medical Services (GMS) contract. The level of deprivation affecting the practice population is below the national average. Income deprivation affecting children and older people is also below the national average.

The practice serves a population that is much higher than average for older people and looks after 260 patients living in local care homes. The practice has 13.2% of patients who are aged 75 or over, which is ranked as the highest in the CCG. They also have 4.7% of their practice list who are aged over 85 years, which is also ranked as the highest in the CCG.

The demand for services related to older people and long term conditions is also higher than local and national averages.

There are facilities for disabled patients, baby changing facilities, and there is car parking.

The clinical team comprises seven GP partners, four male and three female, and a salaried GP. There is a Lead nurse who is the senior nurse practitioner, four other practice nurses and a health care assistant (HCA). The clinical team is supported by a full time practice manager, finance manager and a range of reception and administrative staff.

The practice is a training practice and supports GP registrars in their training and development with a comprehensive mentorship package.

The practice opens from 8am to 6.30pm Monday to Friday and on Saturday from 9am to 12pm. In addition the practice is open until 7.45pm on Mondays at Park Farm and until 7.45pm on Thursdays at Vernon Street on Thursdays.

Consultation times are from 8.20am to 5.50pm Monday to Friday. Extended appointments with a GP are available at Park Farm Medical centre on Mondays from 6.30pm to 7.45pm and at Vernon street surgery on Thursdays from 6.30pm to 7.45pm.

When the practice is closed, patients are directed to the out of hours service via a direct telephone number or advised to contact the 111 service.

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 28 June 2016. During our visit we:

- Spoke with a range of staff (GP partners, practice manager, nursing staff, practice pharmacist, care coordinator, community staff, and care home managers) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had systems and processes in place to enable staff to report and record incidents and significant events effectively.

Staff told us they would inform the practice manager of any incidents. In addition there was a recording template available on the practice's computer system which had recently been updated and staff knew where to find this. 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).The practice carried out a thorough analysis of the significant events which were discussed at weekly practice meetings and bi-monthly clinical meetings as a standing agenda item, and an annual review took place to look back on learning shared and whether changes to practice had been implemented effectively.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared with relevant staff to make sure action was taken to improve safety in the practice. For example, when the wrong tablets were prescribed for a patient who sent in a written request for medicine, the practice changed their request form to include the specific name of the medicine being requested. The practice had also participated in an event with other practices in their locality to discuss significant events and share learning.

The practice had processes in place to review and share any medicines alerts and patient safety alerts received. Safety alerts were received by the practice manager and shared with other members of the staff team as required. Staff told us about actions they had taken to address safety alerts they had received. Medicines and Healthcare products Regulatory Agency (MHRA) alerts were received and shared by the CCG pharmacist who conducted the appropriate searches and informed GPs and nurses of any changes required. These were also discussed at clinical meetings with GPs.

Records showed that where there were unintended or unexpected safety incidents, patients were offered support, information about what had happened and apologies where appropriate.

Overview of safety systems and processes

We saw the practice had robust systems, processes and practices in place to keep patients safe and safeguarded from abuse. These included arrangements to safeguard children and vulnerable adults from abuse which were in line with local requirements and national legislation. There was a lead GP responsible for safeguarding within the practice and staff were aware of who this was. The practice had conducted an audit to review their practice in identifying and managing safeguarding concerns and found that their policy and agreed processes were being adhered to.

The practice had policies and procedures in place to support staff to fulfil their roles and staff knew who to contact for further guidance if they had concerns about patient welfare. Staff had received training relevant to their role and GPs were trained to the appropriate level (level 3). Staff we spoke with were able to give examples of action they had taken, or would take, in response to concerns they had regarding patient welfare.

Information was displayed in the waiting area which advised patients that chaperones were available if required. The nurses and some receptionists acted as chaperones and had been trained for the role and had received a Disclosure and Barring Service check (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.

The practice had arrangements in place to ensure appropriate standards of cleanliness and hygiene were maintained. The Infection Prevention and Control (IPC) lead was a Senior Nurse Practitioner with some responsibility delegated to a lead GP. We saw that current staff had completed infection control training. Regular infection control audits were undertaken, the most recent audit being in February 2016 which was conducted in collaboration with the locality IPC lead. An action plan had been created and some changes planned. For example, to replace the carpets in the consulting rooms with washable floor covering. We reviewed the audit completed in

Good

Are services safe?

February 2015 and saw that actions had been implemented to improve safety. For example; couch rolls had been mounted onto walls so that they were off the floor and carpets in the treatment rooms had been replaced with washable floor covering.

There were effective arrangements in place for managing incoming mail including test results. These were checked daily by GPs, and where a test result showed an abnormal result, a GP would contact the patient on the same day to discuss or make an appointment for them. For test results that were grossly abnormal, a GP would contact the patient immediately to discuss and arrange a home visit if required.

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme which included recording samples taken, the patient's details and name of the sample taker. Any abnormal results were dealt with on the day by GPs who would contact the patient by telephone and invite them for an appointment to discuss further treatment.

Arrangements for managing medicines ensured that patients were kept safe. For example, there was a GP who was the lead for medicines management and worked with the clinical commissioning group (CCG) pharmacist to monitor adherence to protocols relating to prescribing and dispensing. Regular medicines reviews were conducted and actions recommended by the CCG pharmacist were followed up by GPs. There was a temperature monitoring system in the medicines fridges to ensure that vaccines were stored at the correct temperature, and emergency drugs were in date, and regularly checked.

Blank prescription pads and paper were stored securely and processes were in place to monitor their use which included recording serial numbers. Patient Group Directions (PGDs) and Patients Specific Directions (PSDs) were being used by the practice to allow nurses to administer medicines in line with legislation.

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 Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had procedures in place to monitor and manage risks to patients and staff safety. There was a health and safety policy available which was accessible to all staff electronically.
- Fire alarms were tested weekly and records kept, and staff told us they knew what to do in the event of a fire. A fire drill exercise was carried out in May 2016 and a further one planned.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw records of actions taken where equipment required attention.
- The practice had processes in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a bacterium which can contaminate water systems in buildings). There had been a recent risk assessment and water test for Legionella and a certificate provided.
- Arrangements were in place to plan and monitor staffing levels needed to meet patients' needs. There was a system in place for different staffing groups to ensure that enough staff were on duty. Each staffing group had agreements about the number of staff who could be on leave at the same time to ensure service provision was not adversely affected. GPs would cover other GP's annual leave, and a regular locum GP (who used to be a partner at the practice) was utilised for one session each week and additionally where required.

Arrangements to deal with emergencies and major incidents

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

· There was a panic alarm system in all the consultation and treatment rooms which alerted staff to any emergency.

· Basic life support training was delivered annually and there was emergency equipment available which we found to be in date and fit for use.

· There was a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.

Good

Are services safe?

· 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 at each site were in date and fit for use.

· The practice had a comprehensive business continuity plan in place which had been recently updated. This covered major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and a paper copy was available in all GP consulting rooms and also off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice routinely used National Institute for Health and Care Excellence (NICE) best practice guidance and other national and locally agreed guidelines and protocols as part of their consultations with patients. They monitored these guidelines through risk assessments, audits and random sample checks of patient records. The practice had systems in place to ensure all clinical staff were kept up to date. They also kept up to date with current practice by using topics such as patient safety alerts and medicines alerts which were discussed at practice meetings and attended local events where development was available.

Their prescribing for medicines related to older people were slightly higher than the CCG average, however, this was still within CCG target even though they had an older population that was more than double the CCG and national averages and the number of patients registered with a long term condition was 23% higher than the CCG and national averages. The practice worked closely with the CCG pharmacist to provide regular medicines reviews for patients and ensure that prescribing was in line with best practice guidelines.

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 were 96% of the total number of points available, which was comparable with local and national averages. They had an exception reporting rate of 10% which was also in line with local and national averages. (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was 84% which was 9% below the CCG average and 5% below the national average. However, this was achieved with an exception rate of 7% which was lower/better than both CCG and national averages (13% and 11% respectively) The practice told us that this was a performance area that they were aware of and they were providing diabetes specific training for a new practice nurse. This would also enable a nurse practitioner to be released to provide health checks in patients' own homes for those who were housebound.
- Performance for indicators relating to chronic kidney disease was 90% which was 6% below the CCG average and 4% below the national average. Exception reporting for this indicator was in line with CCG and national averages.
- Performance for indicators relating to prevention of heart disease was 96% which was same as the CCG average and 1% above the national average. Exception reporting at 9% was also in line with CCG and national averages.

The practice supplied data for 2015/16 which had been submitted for verification but has not yet been published. Data showed that exception reporting was between 0% and 2% for all the indicators we looked at.

The practice had identified diabetes management as an area for improvement and had plans for a dedicated practice nurse who had received specialist training to make home visits to housebound patients who had diabetes. They had also recently recruited an additional practice nurse who was attending training in long term conditions, including diabetes, to increase the capacity to monitor patients with diabetes.

The practice worked very closely with eight residential and care homes aligned to them and had developed a package of care that included regular structured ward rounds, dedicated time for direct telephone access to a GP daily, and regular communication with relatives. This had resulted in a significant reduction in the number of patients being admitted to hospital from the residential or care home. This had also enabled 99% of these patients receiving end of life care to die in their preferred place.

There was evidence of quality improvement including clinical audit. There had been 12 clinical audits undertaken in the last two years, seven of these were completed audits where the improvements made were implemented and monitored, and a further five audits were ongoing. Audits were used to improve practice and care for patients. For example; an audit was conducted following a medicines

Good

Are services effective?

(for example, treatment is effective)

alert regarding taking two particular medicines together. The practice conducted a search and found that some patients were taking both medicines concurrently, and took action to address this. Further searches showed that the new guidelines for the medicines were being adhered to.

We spoke with the community service manager who told us that patients were usually seen by a consultant within three weeks of referral and that the practice had usually arranged for appropriate tests to be carried out during the waiting time so that test results were available on the day patients saw the consultant.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We looked at the records for recently recruited staff and found that an induction checklist had been completed. A comprehensive induction programme was in use for GPs including locum GPs.
- There was an appraisal system in operation at the practice, and most staff had received their appraisal in the preceding 12 months. The remaining staff had an appraisal scheduled for July.
- Staff were supported to undertake training to meet personal learning needs to develop their roles and enhance the scope of their work. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Development for non-clinical staff included training specific to personal and individual development. For example, there were a number of staff who were undertaking training in additional roles in order to broaden the skill mix of the team. Nurses were also given time and support to address their needs for nurse revalidation.

· All staff had received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

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 the computer system. This included care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs, and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they are discharged from hospital. Where people were admitted to hospital as an emergency, the care coordinator would contact them by phone as soon as they were discharged to check on their welfare and discuss any unmet needs.

The care coordinator was able to arrange for patients to access help and assistance with a range of support programmes through referral to The Live Life Better Derbyshire programme. This included; exercise programmes, weight management programmes, advice about debt and housing, and smoking cessation support sessions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis incorporating reviews of patients at risk of hospital admission, end of life patients, and those who had complex needs. These meetings included a GP, care coordinator, community health team representatives, (community matron, district nurse, health visitor), social work team and the community mental health team where required. Care plans were routinely reviewed and updated and risks assessed. In addition to the practice's usual care plan, patients with complex needs were provided with a Derbyshire Health and Social Care Plan which was comprehensive and shared with relevant services as required.

Each of the eight residential and care homes aligned to the practice had a named GP who visited each home for one morning or afternoon session each month to plan care, conduct medication reviews, meet with patients, relatives and staff. The GP also made shorter weekly visits and urgent visits on the day when required. The practice scheduled dedicated time each day for residential and care home staff to speak to a GP for telephone advice. This had resulted in a 9.1% reduction in visits to the A/E department and a reduction of 22% in unplanned admissions to hospital in the preceding 12 months. The practice were

Good

Are services effective?

(for example, treatment is effective)

proud of their relationships with the patients, relatives and care teams. Feedback from two care homes we spoke with was extremely positive about the care and service provided to residents and regarding the communication with relatives and staff.

Consent to care and treatment

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance, and where a patient's mental capacity was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment. The practice had Fraser and Gillick competence assessments embedded into the computer system to ensure that young people were actively encouraged to be involved in their care. Staff recorded consent to treatment and procedures in the patient's record.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet or smoking cessation. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme was 91% which was higher than the CCG average of 83% and the national average of 81%. Exception reporting for this indicator at 2% was lower than both the CCG and national averages. The practice contacted patients who did not attend for their cervical screening test to remind them that they had missed their appointment and advise them to make a new one. Where patients did not respond to the third letter, a further letter was sent asking the patient to make a face to face appointment with the practice nurse to discuss their decision. This provided an opportunity to allay patients' anxiety and provide additional information to help them make their decision.

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 breast cancer screening. They had achieved an attendance rate of 85% for breast cancer screening which was 7% higher than the CCG average and 13% higher than the national average.

The practice actively followed up patients who did not attend their hospital breast screening appointment by sending a letter to the patient advising of the importance of the test and providing them with the hospital telephone number and their breast screening number so that they could more easily make a new appointment

Patients who were eligible for the bowel screening programme were actively encouraged to attend which resulted in a total of 79% of eligible patients who had attended for bowel screening compared with the CCG average of 61% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% (compared to the CCG average of 94% to 97%) and five year olds from 94% to 99%. (compared to the CCG average of 91% to 97%)

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very 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.

Almost all of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice staff were helpful, friendly, caring, supportive and treated them with dignity and respect. Patients said they felt the GPs were knowledgeable and provided excellent care.

We spoke with four members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their 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 generally above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 98% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%

The practice had provided data from a Friends and Family survey (from January to May 2016) which showed that 13 of the 14 people who completed the survey, said that they were extremely likely to recommend this practice to friends and family. Patients described the service as pleasant, professional and a first class service

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.

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:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.

We spoke with residential and care home staff, who told us that they had a named GP for continuity of care. They said that residents were treated as individuals and their needs were accounted for. For example, the lead GP attended each home for a half day each month as well as a shorter weekly visit on request, to keep patients' care plans updated. The GP involved care home staff and patients' families in decisions where that person was not able to make an informed decision for themselves.

Good

Are services caring?

All the community based staff we spoke with stated that the GPs were approachable, accessible and respectful of their opinions.

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

- Staff told us that 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.
- The practice were proactive in enabling teenage patients to be involved in their care by using the Fraser and Gillick competencies frameworks, which they had embedded into their computer system. This was accessible on opening the patient record.

Patient and carer support to cope emotionally with care and treatment

The practice opportunistically identified carers during routine appointments and when attending with a relative or friend. Carers were offered an appointment with the HCA who was the carers champion and was able to assist them with seeking the support they required through the Derbyshire carers association. Those with urgent or complex needs were referred to the care coordinator

Notices in the patient waiting room told patients how to access a number of support groups and organisations, and a range of literature was available for patients.

The Health Care assistant (HCA) was the appointed practice 'Carers' Champion' to develop the identification and support of carers and had identified 2.6% of the practice list as carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had a written policy that encouraged all clinical staff to opportunistically identify patients who may be a carer whenever they attended for appointments or when they attended with a friend or relative who was being cared for. They were then offered an appointment with the HCA who was able to assist them with seeking appropriate support through the Derbyshire Carers Association. Written information in the form of a carers pack was available to direct carers to the support services available to them. For complex and urgent needs, carers were referred to the care coordinator.

The practice worked to provide high quality standards for end of life care and had written care plans in place to ensure that patient wishes were clear, and that they were involved in the planning of their own care. The practice reviewed patient deaths to ensure that optimal care had been delivered and to consider any learning. The practice team proactively contacted relatives following bereavement, sent a card and a longer appointment with a GP was made available for them soon after their relative had died. We were informed that support was offered, including signposting to appropriate services such as counselling, if this was requested. 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.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice served a population that was much higher than average for older people. For example; 13.2% of patients were aged 75 or over, and 4.7% of their practice list were aged over 85 years, which was ranked as the highest in the CCG. Because of this, they had configured their services to meet the needs of their population.

For example,

- They had recruited a new practice nurse and were providing specialist training for chronic diseases so that another practice nurse could focus on conducting reviews for patients who were housebound and had a long term condition. This was to increase access to this service. Long-term condition reviews were co-ordinated to ensure that patients with more than one condition could be reviewed as part of one appointment. The practice were planning to implement a home visiting assessment service for housebound patients with a long term condition.
- They had developed an enhanced package of care for the 260 residents in the eight residential and care homes aligned to the practice. The practice had recruited a GP whose role was to provide care and support to the homes. This included monthly visits to each home which lasted for half a day to provided structure care planning and discussion with patients, carers, relatives and care home staff. Weekly visits were provided on request and urgent visits daily where needed. The practice also provided care home staff with a dedicated telephone number for the practice and time slots were made available each day for care home staff to discuss any concerns with the aligned GP
- The care home staff we spoke with told us that the practice were very proactive in providing care, supportive of patients there, and were always on hand to ask advice when they needed it. They also told us that the joint educational events provided by the practice for care and residential home staff had been very valuable. The care home managers also confirmed that 99% of residents had been able to die in their preferred place in the preceding 12 months.
- The practice provided data that showed that A&E attendances by residents had significantly reduced over the the preceding 12 months. For example; There had been a 9.1 % reduction in A/E attendances. There had also been a reduction of 22% in non elective admissions to hospital from residential and care homes. The CCG confirmed that the reductions has been a trend across all care homes and GP practices in the area, but that Dr P A A Wood and Partners had achieved a greater reduction than other practices within the locality. This has contributed to an overall A/E attendance rate for the practice being significantly lower than the CCG and national average over the preceding two years
- The practice had worked closely with four other practices to establish a community based service in three specialities. This has enabled consultant and clinical services to be provided in the local area to avoid patients having to travel to hospital. Since setting up the service, it has been extended to seven other practices in the locality and has been recognised by the CCG as a valuable service and commissioned on an annual basis. In the preceding 12 months. Patients are referred to see a consultant for diabetes, musculoskeletal problems and gynaecology problems. This enabled patients to be seen by a consultant in their locality within three weeks instead of travelling to hospital. Usually tests required were performed prior to the initial consultation so that the patient experienced a faster patient journey.
- The practice had adopted a 'floaty rota' system that involved a GP being available for home visits early in the day so that an early assessment could be made and treatment options mobilised early to avoid unnecessary deterioration, or where admission was inevitable, early intervention usually ensured that the patients' journey was less problematic as this was completed during the daytime, avoiding the backlog that often occurs in secondary care during the evenings.

In addition to adjusting its services to meet the needs of the older population, the practice also responded to the needs of other patients, for example;

- The waiting area contained a wide range of information on services and support groups.
- The layout of reception helped to maintain patient confidentiality. The practice told us that they were waiting for information screens that they had purchased to be fitted. A separate room was usually available for private and sensitive discussions.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- There was a phlebotomy service that included anti-coagulant therapy. (anti-coagulant therapy is a medicine to thin the blood to help prevent clotting)
- There was a physiotherapist service available on site.
- The health visitor provided a child health clinic at the practice.
- A representative from the Citizens Advice Bureau attended to provide advice on benefits.
- There was a CAMTAD service held at the practice to assist patients with hearing aids.
- The practice regularly hosted the CRUSE charity at the practice to help bereaved relatives and friends.
- Appointments were available throughout the day. There were longer appointments available for patients who required them, and telephone consultations were available.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The practice told us that requests for home visits were always responded to and this resulted in 10 to 20 visits being made each day. Same day appointments were available every day.
- The premises provided a call bell on the entrance doors for patients in wheelchairs, or those with limited mobility. Services were provided over two floors, and a lift was provided. There was a disabled toilet available for disabled patients and a hearing loop was available for patients who had hearing difficulties. The practice provided two higher chairs for patients who had difficulty in standing from a low seat.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday and on Saturday from 9am to 12pm. In addition the practice was open until 7.45pm on Mondays at Park Farm Medical Practice and until 7.45pm on Thursdays at Vernon Street Surgery.

Appointments were available at both sites throughout the day from 8.20am to 6pm on Monday to Friday, including lunchtimes. Extended hours appointments were available at Park Farm medical Centre on Mondays from 6.30pm to 8pm and at Vernon Street Surgery on Saturday from 9am to 12 midday which patients from both sites could attend.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Telephone consultations were also available and home visits were made for all patients who requested these. (10-20 each day) The practice had a policy of conducting home visits early each day to avoid potential deterioration, commence early assessment and treatment, and to avoid unnecessary admissions to hospital. They had allocated a GP to provide this service each day through a 'floaty rota' system.

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

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 78%.
- 84% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.

People told us on the day of the inspection that they were always able to get appointments when they needed them, although they sometimes had to wait to see their preferred GP.

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.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that comprehensive information was available to help patients understand the complaints system. For example; there was a poster displayed in the waiting areas.

We looked at 19 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints, and action was taken to as a result to improve the quality of care. For example, further to a complaint, the practice had reviewed their processes for booking longer appointments to ensure that patients who needed these were planned appropriately to avoid others having to wait an unduly long time.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had reviewed its processes for managing complaints and had recently implemented a new proforma which was a combined form for managing complaints and significant events. Staff were encouraged to use the proforma online so that trends and analysis could be easily reviewed and so that all staff could access this on their computer.

The practice reviewed complaints in regular practice and clinical meetings and also held an annual review of complaints to discuss lessons learned and to check whether changes to practice had been fully embedded.

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 and purpose to deliver high quality care in a friendly, caring and professional manner. We saw that all staff took an active role in ensuring provision of a high level of service on a daily basis and we observed staff behaving in a kind, considerate and professional manner. The practice had a robust strategy and supporting business plans which reflected the vision and values of the practice. The plans included;

- A resourcing plan
- A succession plan
- A skills matrix
- Flexible working across roles
- Working with student nurses
- Working with medical students
- A number of small projects to enable staff development
- Mentorship courses for relevant staff.

The practice had a mission statement which was displayed in the waiting areas and in all consulting rooms and staff knew and understood the values.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of 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, regularly reviewed and updated and were available to all staff electronically.
- The practice engaged with their CCG, and attended locality meetings and the practice managers' forum to work collaboratively and share best practice.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a thorough meeting structure in place that allowed for lessons to be learned and shared following significant events and complaints.
- A comprehensive understanding of the performance of the practice was maintained
- The practice used information from safety and medicines alerts and development needs to drive a programme of continuous clinical and internal audit, which was used to monitor quality and to make improvements.

Leadership and culture

The senior partner was currently a Lead at the clinical commissioning group (CCG) where he assisted in leading the locality meetings and participated in the Board meetings to determine the future, and make decisions within the CCG. From September 2016 he will become the Chairman of the CCG. He used his knowledge and experience of the wider agenda to inform change and developments with the practice for the benefits of the practice, staff and patients. For example; the practice was the founding practice to take part in the community referral initiative, where patients could be seen by a consultant in their locality instead of hospital for some specialities.

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us 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. Some staff gave examples of how they had been supported during difficult personal circumstances.

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 and 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, information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

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

Are services well-led?

Good

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

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.

· The practice had gathered feedback from patients through conducting surveys and complaints received and from the patient participation group (PPG) The PPG met quarterly and were working with the practice to implement a newsletter for patients.

- The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. For example; development of an enhanced package of care for residents in aligned care homes; development of staff through a flexible role approach where staff were able to work across several roles; and the implementation of a community based service where patients could be seen by a consultant in the locality within three weeks of referral.

The partners were proud that previous registrars have elected to join the practice as Partners on completion of their training.