The Over-Wyre Medical Centre

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as outstanding overall.
(Previous inspection 11/12/2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those retired and students) – Outstanding

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at The Over-Wyre Medical Practice on 12th January 2018. This inspection was carried out 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 was 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.

At this inspection we found:

- There were well established and comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing, equipment and a range of emergencies that might affect operation of the practice. A comprehensive health and safety assessment had been done with actions completed to ensure full compliance.
- The practice routinely reviewed the quality, effectiveness and appropriateness of the care it provided. Care and treatment was delivered according to evidence- based guidelines.We saw that a wide range of clinical audit was carried out.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- Patients were supported by staff to use the online system to book routine appointments which had improved telephone access for others.
- The practice reviewed the needs of their local population and had initiated positive service improvements for patients. They implemented suggestions for improvements as a consequence of feedback from the patient participation group.
- Staff said they felt fully engaged, valued and listened to within the practice team.
- There was evidence that innovation and service improvement was a priority among staff and leaders. High standards were promoted and owned by all practice staff with evidence of strong team working and commitment to personal and professional development.

We saw several areas of outstanding practice :-

- There were six nursing homes in the locality which were served by the practice. Each care home had an allocated GP who maintained regular telephone contact at their respective homes on a weekly or fortnightly basis and undertook monthly ward rounds when required. Additionally the Wyre Integrated Neighbourhood (WIN) Care Home Team was piloted and led by one of the practice GPs which offered clinical triage within two days, holistic assessment, advanced care planning, monthly "ward rounds" and medication reviews. We saw evidence that both hospital admissions and attendance at A&E had been reduced since this team was established.
- Staff understood their role in safeguarding vulnerable patients. They were fully aware they should go to the lead GP for safeguarding for further guidance who had attained a wide range of safeguarding training. The GP held monthly meetings with health visitors, school nurses and practice staff. The lead safeguarding administrator reviewed all correspondence and sent any concerns to the lead GP for review and any further action. A safeguarding folder was used to store all minutes of meetings and referrals in relation to vulnerable adults and children. A regularly updated spreadsheet of all children known to social services was kept. A practice safeguarding self- assessment audit tool was in use to monitor that all aspects of the safeguarding process were managed according to legislative guidelines. The last audit carried out indicated full compliance with recommendations.
- Practice staff had undertaken a project called "Falling for the GP". The purpose was to identify the causes of patient falls, through a risk assessment process and implement actions to reduce these risks. The outcomes from the initiative included increase in patient confidence to self-manage because the risk of future falls had been reduced. The audit and model providing analysis and education had been shared with the clinical team leading to improved physical wellbeing status of frail elderly patients who fell.A protocol had been developed utilising this work and had been shared with the CCG for use by all local teams.
- A virtual ward for patients who required or might require unplanned admissions had been created. This comprised of a wall mounted system to monitor all patients who had been admitted to hospital or were at risk of doing so. Detailed care plans were produced with the multidisciplinary team to facilitate a safe discharge and avoid readmission and individual progress was monitored.
- Staff had increased their resilience by attending a number of leadership development opportunities. For example the Improving Leaders programme, the Productive GP programme and the GP Forward View Time for Care programme. This had led to reviews of a number of processes which improved care and effectiveness of the service provided. For example ordering and administration of repeat prescriptions, communicating test results and managing frequent attenders.

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

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

Summary of findings

Outstanding practice

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The Over-Wyre Medical Centre

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

Background to The Over-Wyre Medical Centre

The Over-Wyre Medical Practice is located in Wilkinson Way in the rural village of Preesall, near Poulton Le Fylde, Lancashire. It is a dispensing practice and there is a branch surgery in nearby Hambleton. We did not visit the branch surgery on this occasion. The link to the practice website is www. overwyremedicalcentre.co.uk.

There are 11033 patients on the practice list. The majority of patients are white British with a high number of patients over 65 years. The practice is in the eighth least deprived decile. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is part of the NHS Fylde & Wyre Clinical Commissioning Group (CCG). Services are provided under a general medical service (GMS) contract with NHS England. The surgery is housed in a privately owned purpose built building and offers access and facilities for disabled patients and visitors. The building was extended in 2017 to create more consulting rooms, waiting areas, a larger dispensary, and improved patient access.

The practice opens from 7.15am to 6.30pm Tuesday to Friday and 7.15am to 8pm on Mondays. Extended surgery hours are available in Fleetwood which is approximately 10 miles away and has poor public transport access from Preesall. When the practice is closed, patients are able to access out of hours services offered by the provider Fylde Coast Medical Services by telephoning NHS 111.

The practice has five male and three female GP partners, an advanced nurse practitioner, two nurse practitioners, five chronic disease nurses, two treatment room nurses, four healthcare assistants, a practice manager, a deputy manager, a clinical coordinator, a clinical pharmacist and a team of reception and administration staff.

The practice had two GP partners who were trainers and led placements to medical students and GPs in training.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- The practice had well established and comprehensive systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. Staff were fully aware they should go to the lead GP for safeguarding for further guidance. The GP held monthly meetings with health visitors, school nurses and practice staff and attended a two monthly safeguarding forum which provided training and discussion of serious case reviews. The lead safeguarding administrator reviewed all correspondence relating to patients under the age of 18 years and sent any concerns to the lead GP for review and any further action. A safeguarding folder was used to store all minutes of meetings, referrals and a regularly updated spreadsheet of all children known to the practice and social services. A practice safeguarding self- assessment audit tool was in use to monitor that all aspects of the safeguarding process were managed according to legislative guidelines. The last audit in January 2018 carried out indicated full compliance with recommendations.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The lead GP had attained a wide range of safeguarding training including level 3 in Safeguarding Children, Child Exploitation Awareness and The Primary Care Response to Domestic Violence. All staff knew how to identify and report concerns.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).Practice staff had struggled to carry out the identity checks required of students on apprenticeships and were currently discussing this with the college assessor to resolve the situation.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). A nurse practitioner was the IPC lead and conducted IPC audits for the practice. These audits showed that the practice achieved the expected levels of compliance. The recent building improvements included new vinyl flooring in all consulting rooms which helped to reduce the risk of infection.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. We saw evidence of a comprehensive health and safety risk assessment was available and reviewed annually.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- 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.

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were agreements in place to share patient information with the local hospital and the out-of-hours service.
- Referral letters included all of the necessary information and urgent referrals were made in a timely fashion and monitored to ensure that patient appointments were made.
- The advanced nurse practitioner (ANP) had established a monitoring system to ensure patients discharged from hospital were followed up and worked jointly with the practice pharmacist to ensure patients received the medicines prescribed.

Safe and appropriate use of medicines

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

- The systems for managing medicines were monitored by the practice pharmacist, including vaccines, medical gases, emergency medicines and equipment. The practice has appropriate equipment to respond to any emergencies including emergency medicines. The practice kept prescription stationery securely and monitored its use. Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Alerts were received by the practice manager, one of the GPs and the pharmacist who reviewed them and e-mailed appropriate staff to take action. For example when dealing with the high risk medication "methotrexate" the practice had a template letter that was sent to the patient which fully explained important clinical information about the medication as well as highlighting the importance of regular monitoring of blood tests. The practice had identified the increasing use of the Direct Oral anticoagulants (DOAC, used to thin the blood) and the importance of having a robust system that ensured patients receiving DOACs were aware of the risks in taking this medication. Regular reviews were undertaken which identified those patients that may require a dose adjustment or in whom the use of DOACs may no longer be appropriate.
- The practice had audited antimicrobial prescribing, in particular usage for recurrent urinary tract infections. There was evidence of actions taken to support good
- Arrangements for dispensing medicines at the practice kept patients safe. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality dispensary services to patients. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular review of these procedures in response to incidents or changes to guidance in addition to annual review.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- 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 that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a comprehensive system for recording and acting on significant events and incidents. A process of root cause analysis had been introduced to investigate incidents and events which identified factors in the occurrence and supported staff in taking corrective action. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and

Good

Are services safe?

shared lessons at practice meetings including the root cause analysis tool with the CCG, NHSE and other local practices, identified themes and took action to improve safety in the practice. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. For example, a number of dispensing errors had been audited in January 2018 and had led to a reorganisation of the items stored to reduce errors in picking out medicines and any distractions for staff had been minimised.

- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. For example, the Medicines and Healthcare products Regulation Agency (MHRA) had issued warnings about the risks of taking valproate medications during pregnancy, and the practice had responded to this by developing an automated way of alerting the prescriber to the enhanced needs of female patients of reproductive age who were prescribed sodium valproate. All prescribers were completing a checklist with the patient to ensure they understood the risks involved.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had effective 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. For example, the practice had developed protocols for the management of patients with long-term conditions.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data for the practice for 01/04/2016 to 31/03/2017 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was comparable to local and national averages; 0.9, compared to 0.8 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was slightly higher than local and national levels; 1.3 compared to 0.99 locally and 0.98 nationally.
- Data for the prescribing of antibacterial prescription items that were Cephalosporin's or Quinolones showed that practice prescribing was comparable with local and national levels; 3.6% compared to 3.0% locally and 4.7% nationally.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The duty GP reviewed all blood test results and ensured they were appropriately followed up.
- Locum GPs completed a handover sheet detailing patients seen and any key actions taken which was reviewed by the duty GP.
- GPs were clinical leads for specific health conditions such as cancer, diabetes and asthma. GPs were supported by members of the nursing team who also had clinical leadership roles for specific areas.
- Nurses took responsibility for preparation and review of policy and protocols in their respective areas of clinical leadership, taking account of NICE guidelines and were supported by the named lead GP for that area in doing so.

Older people:

- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. One of the GPs had a special interest in frailty and had undertaken a teaching session with the clinical team. All the notes of the patients on the frailty register had been reviewed, approximately 300 patients in number.
- Patients were invited for health care and medication reviews, the practice worked with the WIN(Wyre Integrated Neighbourhood) pharmacist to deal with polypharmacy issues in the care homes (particularly aroundlong term medications that were no longer required) and captured some reviews opportunistically when frail patients had presented at the practice. Details of medication changes were sent to the care homes when adjustments were made and inviting them to feedback if there were any issues. A total of 161 patients in care homes had been reviewed by January 2018 and 100% of patients over 75years had been placed on the frailty register.
- The advanced nurse practitioner (ANP) had undertaken a project in January 2017 for her ANP qualification called "Falling for the GP". The purpose was to identify the causes of patient falls, through a risk assessment process and implement actions to reduce these risks. The twenty patients identified with falls (equated to the more frail patients on the register) were reviewed and referrals were made to the falls team if appropriate. The care plans written included issuing a 24 hour helpline telephone number and regular contact with the ANP and were shared with other agencies including the ambulance service and Out Of Hours service which were able to access information en-route to the patient's home. The outcomes from the initiative included

increase in patient confidence to self-manage because the risk of future falls had been reduced. A total of 99 falls patients have now been integrated onto the frailty register. The project leader provided analysis and education which had been shared with the clinical team leading to improved physical wellbeing status of frail elderly patients who fell.A protocol had been developed utilising this work and had been shared with the CCG and implemented by all local teams.

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.Over a 12 month period the practice had carried out 237ofthese checks, 178 of which had been carried out at a home visit.
- The practice had a significantly higher patient population aged 65 or above (The Over-Wyre 35% over 65 years National average 24%) however it had achieved significantly less A&E attendances (Practice value 241, national average 352 July 2015-June 2016 data from Primary Care Website). Data for 2016/17 was not available as yet.
- 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. One GP was allocated to each of the six nursing homes in the area, providing regular telephone advice and support and undertaking home visits as needed.

People with long-term conditions:

The prevalence of chronic disease was significantly higher than the national average and above the average for the CCG. The population prevalence rates are consistently in the top 2% nationally; this demonstrated a high level of healthcare demand locally. For example the prevalence of coronary heart disease at the practice was 1.02, CCG 0.89, national 0.69 and prevalence of chronic obstructive pulmonary disease was 1.49 at the practice, CCG 0.99 and nationally 0.64. However the practice had a lower than national average rate of admission to hospital. For example, practice value for admission with coronary heart disease was 6.0, CCG 6.4, national average 7.6 (figures for July 2015-June 2016 Primary Care website).Data for 2016/17 was not available as yet.

- 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. One nurse had attended training in spirometry relevant to the treatment of patients with asthma and two nurses in the initiation of insulin which prevented patients from having to be referred to secondary care when insulin initiation or change of insulin was needed. Practice staff also care for Type1 diabetics so they did not need to attend out-patient appointments.
- Blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 92% of patients had well controlled a blood sugar level which was higher than the clinical commissioning group (CCG) average of 83.5% and national average of 79.5%. Hospital admissions for patients with diabetes were below the national average (practice value 1.06, CCG 1.18, national average 1.5)
- The percentage of patients with hypertension (high blood pressure) in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 89%, also higher than the CCG average of 83% and the national average of 83%.
- To help prevent unplanned admissions throughout winter, the practice had a register of COPD (Chronic Obstructive Pulmonary Disease) patients that were more at risk of admission. Staff commenced recalling these patients in September to ensure that they had inhalers and standby antibiotics in place and an updated care plan. Hospital admissions for COPD were significantly lower than the national average. (Practice value 9.6, CCG 10.65, national average 11.8)

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90% for all four indicators.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Practice staff had received triage training to recognise sepsis and there was a prompt on patient records to remind clinicians to identify potential symptoms when seeing patients.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines and pertussis vaccination was available.
- Appointments out of school hours were available.

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

- The practice's uptake for cervical screening was 75%, which was below the 80% coverage target for the national screening programme. This was a reduction in the data from the previous year due to long term staff absence. Patients were redirected to the local family planning clinic during this time. The practice provided unvalidated data for 2017/18 to indicate an achievement of 89% at the day of inspection.
- 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.
- A full range of health promotion and screening which reflected the needs for this age group was available. For example, Meningitis ACWY immunisation for new students.

People whose circumstances make them vulnerable:

- The practice had appointed a GP partner as a lead for vulnerable patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Palliative care meetings were held monthly to discuss people's needs. In conjunction with the hospice and district nurses the practice staff had carried out reviews with all patients expected to die within 12 months to make plans with the patient and family. The ANP acted as cancer champion ensuring that a wide range of information was made available to patients and their families and they were signposted to appropriate services.
- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. Staff proactively engaged with the travellers, inviting representatives into the practice to welcome them to the service, managing their expectations of it and discussing how they could best work together.

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

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 99%; CCG 92%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 99%; CCG 96%; national 95%).
- The practice provided a single point of access to counselling services for those with poor mental health. Counsellors and a child psychologist carried out clinics at Over Wyre Medical Centre.
- The GPs supported several nursing homes where people were diagnosed with dementia. All staff had undertaken dementia awareness training.

Monitoring care and treatment

The practice had a well-established comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, a range of audits had been completed including of antipsychotic prescribing in patients with dementia, reviewing practice adherence to the GOLD (Global Initiative for COPD, guidelines for healthcare professionals to use as a tool to implement effective management programmes) for management of COPD, the risk of bleeding when using aspirin, the prescribing of valproate for women of childbearing age, management of patients with recurrent urinary tract infections. Staff had completed a dispensary audit in January 2018 focussing on errors from October –December 2017. This resulted in changes to ensure increased

accuracy. A subsequent re-audit was planned for April 2017. Two of these audits were reviewed by the CCG led PQIP Inspection and received recognition as the best they had received across the locality.

The practice pharmacist worked with members of the CCG pharmacy team to ensure that practice prescribing was carried out in line with local and national recommended guidelines.

Audits undertaken had led to improvements in clinical practice for example advising relevant patients of the risks of taking aspirin, developing a protocol for the management of patients with COPD, adding a new prompt to the patient records for prescribers considering the use of valproate, offering self-help advice and review of repeat prescriptions for patients experiencing recurrent urinary tract infections.

The practice had a data coordinator who led a data management team. They had devised a comprehensive work flow system that captured and validated information from the records of new patients summarised and coded it. This drove an accurate and effective recall system for management of long term conditions. A system was in place that was used to screen out excessive paperwork which need not be seen by GPs.

We saw evidence that the establishment of the Wyre Integrated Neighbourhood Care Home Team led by one of the GPs had reduced attendance at the Accident and Emergency (A&E) department from 12 in December 2015 when the service started to 4 in December 2016. Further, in October 2017 whilst there were 430 active patients, including 24 new patients, there were no hospital admissions and no A&E attendances.

The most recent published Quality Outcome Framework (QOF) results were 99.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.2% and national average of 96.5%. The overall exception reporting rate was 9.9% which compared with a CCG average of 9.6% and a national average of 9.6%. (QOF is a system intended to improve the quality of general practice and reward good practice. 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.)

- The practice used information about care and treatment to make improvements. For example following the impact of introducing ANPs at other practices this practice supported one of its nurse practitioners to train as an ANP. The ANP triaged requests for home visits, oversaw all discharge letters and assigned the patient to the appropriate long term care nurse for follow up. They also acted as the practice care coordinator running a virtual ward for patients who required or might require unplanned admissions. This comprised of a wall mounted system to monitor all patients who had been admitted to hospital or were at risk of doing so. Detailed care plans were produced with the multidisciplinary team to facilitate a safe discharge and avoid readmission and individual progress was monitored.
- The ANP also led on end of life care and new models of care.
- The practice pharmacist carried out medicines audits to check practice prescribing and adherence to best practice guidelines. Where appropriate, clinicians took part in local and national initiatives by arranging training for non-clinical staff in change management, leadership and process mapping as part of increasing the resilience of the practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, the lead GP in safeguarding had attended training at level 3 in Safeguarding Children, level 2 in Safeguarding Adults, Child Exploitation Awareness, a Mental Capacity Act Case Law Update and The Primary Care Response to Domestic Violence. NThe health care assistants had been trained in wound care in order to work effectively

in the treatment room. Nursing staff had also been supported to progress academically and professionally with one becoming a nurse practitioner in 2016 and another progressing to ANP in 2017.

- The GPs ran regular training updates for all clinical staff in their areas of specialism for example asthma prescribing, prevention of exacerbation in COPD, identification and management of delirium and frailty. The ANP had run a training session for the full staff team on falls management and introduced the new multidisciplinary protocol. There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training, or were fully supervised in apprenticeship roles, and had undertook continuing learning and development. Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary.
- The practice provided staff with staff with ongoing support. This included an induction process, one-to-one meetings, annual appraisals for all staff, coaching and mentoring, clinical supervision and support for revalidation.
- The induction process for healthcare assistants included the requirements of the Care Certificate.
- A system to audit clinical decision making and non-medical prescribing for clinicians working in advanced roles was implemented. These staff were supported with regular supervision.
- A confidence mapping tool was in use by nursing staff to report on their competence in managing type 2 diabetes which they discussed with the lead GP during supervision and identified any support required.
- There were clinical meetings including GPs and nursing staff on a fortnightly basis and nursing staff met as a team every six weeks to discuss complex cases, cascade new initiatives, review access to appointments and learn together from complaints and grievances.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- 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 held regular multidisciplinary team meetings to discuss the needs of complex patients, for example, those with end of life care needs. They also worked in collaboration with the local hospital to meet the needs of patients prescribed warfarin. For example, the hospital warfarin clinic carried out blood testing in a local church hall to establish an appropriate dosage which the practice then prescribed and dispensed. If a patient was subsequently prescribed medication that may interact with warfarin, systems were in place to promptly alert the warfarin service.
- 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. There were palliative care meetings every month to review patients receiving end of life care.

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 health. The practice provided specialist care in diabetes and was able to refer patients who had been identified as at risk of developing diabetes to a national diabetes prevention and management programme.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice encouraged patients to attend national cancer screening programmes. We saw that 65% of invited patients had undertaken bowel screening compared to the CCG average of 63% and 54% nationally.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A detailed consent form had been produced by practice staff to raise patient awareness of the interventions proposed and ensure their understanding.
- 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 with a detailed form providing information to patients which ensured informed consent.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. For example:

- Staff understood patients' personal, cultural, social and religious needs. All staff had trained in understanding equality and diversity.
- Alternative means of communication were available to patients such as text and email. Translation services and extended appointment duration were offered and the practice had facilities for patients with a hearing loss.
- The practice gave patients timely support and information.
- Two members of the reception team had been identified as patient customer services managers due to their strong people skills and whenever possible they dealt with concerns and first stage complaints from patients.
- 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.
- All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced and there was one card which referred to experiences of secondary care. Results of the NHS Friends and Family Test for 2016/17 indicated that 94% of patients would recommend the practice. Feedback on the NHS Choices website over the past year was very positive including "always a fantastic service" and "excellent care".

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 222 surveys were sent out and 120 were returned. This represented about 1.06% of the practice population. The practice was generally comparable with others for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 93% of patients who responded said the GP gave them enough time; CCG - 94%; national average - 92%
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG – 95.5%; national average – 95.5%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 87%; national average – 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 92% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 95% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 79% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

The practice also carried out its own survey in 2016 which gained 408 responses and in conjunction with the Patient Participation Group (PPG) had developed an action plan in response to the results. This included improving access to appointments, telephone access, ordering repeat prescriptions and activity to expand the PPG by encouraging new members and advertising the dates of meetings We saw that action had been taken to address all of these issues. A survey had been carried out in December 2017; however the results were not available on the day of our inspection.

Involvement in decisions about care and treatment

Good

Are services caring?

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

- Interpretation 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.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Staff were alerted to patients with visual or hearing difficulties by means of alerts on patient clinical records.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers by discussing their caring roles during consultations and health checks and using posters in waiting areas asking them to inform the practice of their role. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 307 patients as carers (2.7% of the practice list).

- Newly identified carers were given a Carers Pack providing them with guidance and advice about how to access support of various kinds. A leaflet about the role of the carer had been co-produced by the practice and n-compass carers service (a local charity) to help carers identity themselves, provide useful local agencies and to offer advocacy to carers and their families. The office manager acted as a carers' champions to help ensure that the information about various services supporting carers was available and Carers Packs well stocked.
- Practice staff ran quarterly coffee morning to support carers in partnership with n-compass, a voluntary sector agency.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

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:

- 87% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

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. Staff understood the needs of its population and tailored services in response to those needs. For example:

- Appointments were available from 7.15 to 6.30pm Tuesday to Friday and 7.15 to 8pm on Mondays.
- Online access was promoted via posters in the waiting room, by reception staff on the telephone and on the practice website. An open afternoon had been held for reception staff to help patients to go online and get signed up for online services.
- The practice was situated in a rural community and patients did not have easy access to healthcare in local towns due to the distance involved and the frequency of public transport. The nearest Walk-In Centre was situated in Blackpool. The practice had therefore responded with early and late appointments; however staff were in the early stages of developing a new partnership with two local practices with similar problems to review extended hours arrangements. The practice also employed nursing staff who ran a treatment room which included wound care. This was open from 7.15am daily and provided an alternative to patients attending an urgent care or minor injuries centre.
- The facilities and premises had been upgraded to enable more clinical appointments to be offered with an additional eight consulting rooms, a minor operations room and upgrading existing rooms to improve infection control and access for patients.
- The redevelopment of the practice had created reasonable adjustments when patients found it hard to access services. For example more consulting rooms were available on the ground floor to support patients with mobility problems, automated doors into the practice, better car parking and better access to disabled toilets.
- Consultations appointments with GPs could be extended to 20 minutes to discuss complex concerns, prescriptions could be delivered to patient's homes and flu vaccines and health checks could be carried out on home visits.
- The practice staff used easy read information for patients with difficulties in reading including a leaflet to explain the information kept in care records.
- A local charity provided interpreters for deaf patients when clinicians undertook home visits.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services and directly accessible from practice staff.
- Self-care leaflets were in use by practice staff to help patients to maintain healthy lifestyles and keep their condition stable.

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 offered home visits, telephone consultations and weekly telephone calls to care homes to determine if a GP visit was required. Each care home had an allocated GP who maintained regular telephone contact at their respective homes on a weekly or fortnightly basis and undertook monthly ward rounds when required. The care homes were also served by the Wyre Integrated Neighbourhood (WIN) Care Home Team piloted and led by one of the practice GPs which offered clinical triage within two days, holistic assessment, advanced care planning, monthly "ward rounds" and medication reviews.
- The advanced nurse practitioner (ANP) ran a virtual ward for patients who might require unplanned admissions. Those assessed as high risk were monitored and detailed care plans were produced with the multidisciplinary team to avoid admission. Those patients who were admitted to hospital were assessed for the risk of future unplanned admissions, their safe discharge was facilitated and plans put in place to avoid readmission.
- Patients with complex needs were offered longer appointments.

People with long-term conditions:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with a long-term condition 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 and community matron to discuss and manage the needs of patients with complex medical issues.
- The practice offered an enhanced service to diabetic patients that involved both the GP and the practice nurse specialist in diabetes and referred patients to the diabetic education programme which was run at the practice. Patients had no need to go to the hospital in Blackpool unless their needs were very complex.
- Patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) were reviewed regularly, medicines and advice given to prevent exacerbation and were provided with rescue packs if appropriate.

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 children and young people identified by staff as at risk were identified to the lead GP for safeguarding, discussed at the next safeguarding meeting and a record was placed in a safeguarding folder so that staff could refer to the information when needed.
- All parents or guardians calling with concerns about a child under the age of five years were offered a same day appointment and children aged 5-18years could access a same day appointment when necessary .The practice ensured that appointments were always available after 3pm each day to accommodate children who had become ill while at school.
- One of the nurses was specifically trained as a child chaperone. Children and young people were treated in an age appropriate way and recognised as individuals.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, opening hours from 7.15am to 8pm on Mondays and until 6.30pm Tuesday to Friday.
- Patients could book appointments and order repeat prescriptions online.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability.
- Patients with complex needs were offered longer appointments.
- There were monthly meetings with other health and social care professionals to discuss the care and treatment of vulnerable patients. The practice followed the Gold Standard Framework (GSF) for end of life care which was evidence based guidelines to deliver high quality end of life care. This placed emphasis on responding to patients wishes for example when they wished to die at home. Each patient was assessed according to their needs for support and a clinician was identified to take responsibility for this.
- The practice had identified that some patients found it difficult to keep on top of the timely ordering of their regular medications. In these cases the practice offered a service whereby the patient was proactively contacted by telephone each month by a member of the dispensary staff to enquire as to whether their monthly medication order was required.
- Patients who had been discharged from hospital were followed up by the ANP who ensured that their medicines were reviewed by the pharmacist and that a follow up appointment with a clinician was offered. If the patient did not attend their appointment further contact was made.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

This population group was rated good for responsive care. For example:

- There were named GP leads for mental health, depression and dementia. Staff interviewed had a good understanding of how to support patients with mental health needs. Patients with mental health problems particularly those under 30 years got a double appointment slot to give them time to discuss their concerns.
- Staff described how the practice supported families where older parents with dementia could no longer live independently by working jointly with social services.
- The practice provided a single point of access to counselling services for those with poor mental health. Talking therapies were available at the practice preventing the need for journeys into Blackpool or Fleetwood. The practice also signposted patients to support groups, voluntary and community organizations. Staff was proactive in promoting the Big White Wall Service, a self-help counselling service for those with mental health issues.
- The practice also had a recall system in place for those diagnosed with MCI (Mild Cognitive Impairment) to ensure any preventative measures could be taken.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed as appropriately as possible. There was a one week wait for non-urgent appointments which could be longer if the patient wished to see a specific GP. Practice staff were well aware of this and had taken steps to improve this.
- Patients with the most urgent needs had their care and treatment prioritised.
- Practice staff told us that some patients did not feel the appointment system was easy to use due to delays in the phone being answered however PPG representatives reported this was much improved due to an improved telephone system with more lines and a recent change to ordering medicines online only.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally higher or comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 90% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 82% and the national average of 80%.
- 73% of patients who responded said they could get through easily to the practice by phone; CCG – 77%; national average - 71%.
- 83% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 79%; national average 76%.
- 89% of patients who responded said their last appointment was convenient; CCG - 85%; national average - 81%.
- 81% of patients who responded described their experience of making an appointment as good; CCG - 76%; national average - 73%.
- 72% of patients who responded said they don't normally have to wait too long to be seen; CCG - 65%; national average - 58%.

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 and it was easy to do. Staff treated patients who made complaints compassionately. Patient customer services managers dealt with concerns and complaints at the first stage and advised patients about the process if they wished to formalise the issue.
- The complaint policy and procedures were in line with recognised guidance. Seventeen complaints were received in the last year. We reviewed all of these complaints and found that they were satisfactorily handled in a timely way. All complainants received an apology for their experience.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice learned lessons from individual concerns and complaints and also from an annual analysis and review of trends. It acted as a result to improve the ongoing quality of care. For example, when a clinical test result was given in error by a receptionist a new protocol was introduced to ensure only clinicians relayed test results in future. These concerns were discussed at practice meetings and decisions regarding actions were minuted.

Are services well-led?

Outstanding ☆

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

Our findings

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

Leadership capacity and capability

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

- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The current difficulty of recruiting GPs had been considered and acted upon by expanding the team with two GP trainers. This meant the practice was now hosting GP trainees who could be encouraged to join the practice when they qualified. One GP trainee told us they felt supported, were given an excellent induction plan and had exposure to a wide range of opportunities including chairing a practice meeting and undertaking audits.
- During 2017 the practice partners invested funds in order to extend and modernise the building. This major initiative was taken to address patient service demands for example access to facilities for the disabled, creating a larger dispensary, and many additional consultation rooms for the expansion of the clinical team.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff reported a positive, happy atmosphere and easy access to advice and support.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. One of the senior GPs was preparing to become the Registered Manager when the current senior partner retired. An assistant Practice Manager had been appointed and was being developed in-house as a potential successor to the current manager.
- There was a commitment to developing the staff team with a view to increasing the practice's resilience to meet future challenges. For example the practice manager, assistant manager and dispensary supervisor had attended the six day residential Improving Leaders programme, the practice team had completed the four month Productive GP programme, and three staff attended the GP Forward View Time for Care programme.

.Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. This vision was "to provide patients registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. We aim to achieve this by developing and maintaining a happy sound practice which is responsive to people's needs and expectations and which reflects whenever possible the latest advances in Primary Health Care". The practice leaders met every two weeks to discuss performance, finance and service strategy and had a supporting business plan 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. For example in response to the rural local community and consequent difficulty accessing extended services in Fleetwood the practice had extended their hours of service delivery with early mornings and one late night. The practice had commenced joint working with the newly formed Neighbourhood Practice group of three practices who each experienced similar issues.

Are services well-led?

Outstanding ☆

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

- Another local priority was anticipatory care to prevent hospital admissions and wherever possible have patients cared for at home. This meant that patients with complex needs required enhanced care plans .Practice staff had an effective review and recall system, worked with the Wyre Integrated Neighbourhood (WIN) team and had also developed a virtual ward to monitor and prevent readmissions for patients over 65 who had chronic disease.
- The practice monitored progress against delivery of the strategy which was being updated quarterly. Progress was discussed with the Patient Participation Group (PPG) and at practice meetings and a dedicated notice board was in place to promote new initiatives to patients and visitors.

Culture

The practice had a culture of providing open, friendly care and going the extra mile to provide support.

- Staff stated they felt respected, supported, valued and could voice their views and ideas at meetings and with leaders. They were proud to work in the practice, described positive relationships between staff teams and felt that there was good teamwork. We saw that many of the staff had worked for the practice in the long term. Staff were regularly nominated for awards with local newspapers and the Patient Participation Group (PPG) had won the CCG PPG of the year award in 2016.
- We saw that the practice focused on the needs of patients. All fortnightly clinical staff meetings were minuted with detailed actions to improve the quality of care for patients.
- Leaders and managers acted on behaviour and performance which was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Patients were offered apologies wherever appropriate and were invited to the practice to discuss any outstanding concerns. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. For example, holding regular meetings to share events and complaints and to learn from what took place and sharing tools with other practices, the CCG and NHSE.
- 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. The practice manager did a morning walk around every day to stay in close contact with staff and their door was open to staff queries and concerns.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year which were clearly documented. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. All clinical staff had time set aside for administration and group supervision. All surgery staff were able to train together at professional development sessions on a monthly basis.
- There was a strong emphasis on the safety and well-being of all staff .Staff were all involved in a staff celebration and planning team building day and partners attended a strategy day. These two events led to the production of the comprehensive five year business plan.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- **Governance arrangements**

  There were clear responsibilities, roles and systems of accountability to support good governance and management.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. Every two weeks GPs, nurses, the pharmacist, data coordinator and representatives from the district nursing team met to

Are services well-led?

Outstanding ☆

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

share knowledge about patients, discuss concerns and identify improvements needed. Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

- **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 developed a strong safeguarding system with a well- trained lead GP, monthly meetings with practice and community staff, review of all correspondence relating to patients under the age of 18 years, a folder to store all minutes of meetings, referrals and a spreadsheet to capture information about vulnerable patients. An audit tool was in use to monitor that all aspects of the safeguarding process were managed according to legislative guidelines.
- Locum GPs were required to complete a handover sheet summarising information about their work and passing information to the duty GP for review and action.
- 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 Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints. The practice had employed a full time clinical pharmacist who had, with the dispensing and reception team reviewed the prescription system and updated it to improve patient safety, ease of making requests and speed and efficiency of processing orders.
- 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 ongoing service developments and where efficiency changes were made this was with leadership 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 two weekly meetings with clinical staff and we saw formal minutes of these meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

- **Engagement with patients, the public, staff and external partners**

  There were consistently high levels of constructive engagement with staff and people who used services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. Services were developed with the full participation of those who used them, staff and external partners as equal partners. For example:-

- There were regular Patient Participation (PPG) meetings, NHS Choices feedback received consistent responses, Friends and Family Test (FFT) responses were monitored and staff attended CCG and locality meetings. A PPG rep told us clinical staff were well represented at PPG meetings with GPs, nurse practitioners, practice manager and office manager in regular attendance. Improvements following PPG suggestions included providing a comfy chair for nursing mothers, extending

Are services well-led?

Outstanding ☆

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

practice opening hours, improving telephone access, putting up a PPG information board, improving disabled access, introducing new patient feedback forms, and ensuring that urgent same day appointments were available at first phone contact. The PPG felt they worked successfully with practice staff as critical friends.

- The practice had improved engagement with patients and the general public through monthly contributions to the Over-Wyre magazine, a practice newsletter, the website and on Facebook.
- One of the GPs had a split post between the practice and the CCG which meant staff were kept up to date with new initiatives and were frequently involved in piloting new services such as the Wyre Integrated Neighbourhood (WIN) Care Home Team.
- Staff had attended the Productive General Practice Programme which resulted in improvements generated and led by staff. For example a review of frequent patient attenders had led to more individualised approaches to providing support, unhelpful variations in approach had been identified and a common approach agreed. Practice communications had been reviewed to improve effectiveness. The benefit of the programme was the introduction to process mapping which had become a standard approach to service improvement.
- The service was transparent, collaborative and open with stakeholders about performance including sharing lessons learnt from serious events and the recording system they had adopted.
- **Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the practice, this included development of protocols following serious events, improving administrative systems after complaints, responding to data in relation to prescribing and an ongoing review of how to offer better access to appointments.
- The practice was committed to working with other practices The practice had been named the CCG Most Engaged Practice for 2017. An example of partnership working was the development of services such as extended opening hours and developing the Wyre Rural Extended Neighbourhood (WREN) Care Home Team of which one GP was the Chairperson.
- A GP partner attended the CCG Council of Members and two of the partners were GP specialist leads. The practice manager and practice nurses attended regular CCG forums.
- Staff knew about improvement methods and had the skills to use them such as process mapping and root cause analysis. The falls protocol developed by the ANP had been adopted by the CCG. The NHSE had approached practice staff to present their work on change and improvement at the Time for Care event in the North West in early 2018.
- The practice made use of internal and external reviews of incidents and complaints such as sharing their methods of significant event analysis with the CCG and NHSE.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance such as the planning and strategy events held in the autumn of 2017.