Sutherland Lodge Surgery

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?	Outstanding ☆
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 Sutherland Lodge Surgery on 14 October 2015. Overall the practice is rated as outstanding.

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.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- There was a strong commitment to providing co-ordinated, responsive and compassionate care for patients, particularly people experiencing poor mental health (including people with dementia) and older people who are frail and at risk of memory loss.
- Information about services and how to complain was available. The practice actively sought patient views about improvements that could be made to the service and worked with the Patient Participation Group (PPG) to do this.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Summary of findings

- The practice proactively sought to educate their patients to manage their medical conditions and improve their lifestyles. Additional in house services were available and delivered by staff with advanced qualifications, skills and experience.
- The practice used audits and had shared information from one of their audits with other practices to promote better patient outcomes.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice employed a mental health nurse that worked collaboratively with the GPs to develop mental health care plans. She held her own patient lists that were patients that had been referred to her by the GP. Patients could be referred directly into the mental health services, signed posted to support groups and receive support from the practice.
- The practice carried out a bi-monthly skin clinic ran by a GP with a diploma in dermatology. This GP liaises closely with the local Dermatology consultant and has reduced the number of hospital referrals by being able it identify and treat minor symptoms locally. Data showed that the practice referral rates to hospital were lower than national and CCG averages for skin legions.
- The practice used a form called 'for you about you'; this contained information that is useful for other medical professions and contained the patient's medical history as well as their thoughts and wishes about the level of care they wanted to receive.
- The practice provided training and teaching to medical students and GP trainees, they also offered a placement to student nurses.

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. When something went wrong, people received a sincere and timely apology. They were told about any actions taken to improve processes to prevent the same thing happening again.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibility to raise concerns and report incidents and near misses in a timely way; they were fully supported when they did so. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used every opportunity to learn from internal and external incidents, to support improvement. Lessons were learned and communicated widely to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Evidence showed guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing highly when compared to neighbouring practices in the CCG The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care.

We saw a holistic approach to assessing, planning and delivering care and treatment to people who used the services. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence based techniques and technologies were used to support the delivery of high-quality care.

Summary of findings

Staff, teams and services were committed to working collaboratively. People who had complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to people who used the services.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. In September 2015, 100% of the friends and family test responded they would recommend this surgery to someone new to the area. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a strong patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. The practice contacted all patients within 48 hours of a bereavement to offer ongoing support. We were told that many patients with extra needs nearing the end of life had their named GPs telephone number and email address to enable them to contact them out of hours. We saw that all newly diagnosed cancer patients were contacted by their named GP. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings. We saw examples of joint working with other practices, the local trust and other professionals. The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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.

Patients and staff worked together to plan care and there was shared decision-making about care and treatment. Staff responded compassionately when people needed help and support when required. Patient's privacy and confidentiality is respected at all times.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patient's social needs are understood. They were enabled to manage their own health and care when they could.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group

Summary of findings

(CCG) to secure improvements to services where these were identified. Examples of these were mental health care, dementia care, care of people in care homes and end of life care. The practice manager and a GP attended locality meetings quarterly and linked to the Primary Care Forum.

The practice interacted with the Patient Participation Group (PPG) and shared information with their members. Patients said they found it easy to make an appointment with a named GP and that 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 was accessible to people with disabilities and staff relocated to the ground floor to see patients when needed. Information about how to complain was available in the practice and on the practice website, it was easy to understand and evidence showed that the practice responded quickly to all complaints. Learning from complaints was carried out but not shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. The practice reviewed this every six months to review developments and progress. High standards were promoted and owned by all practice staff, and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. Clinical and internal audit processes functioned well and had a positive impact. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

A full and diverse range of views and concerns from people who used the service were encouraged, heard and acted on. Information on patient's experience was reported and reviewed alongside other performance data.

There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

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 ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were consistently above the national average for conditions commonly found in older people. The practice had introduced a number of initiatives to improve the care of older people. They had identified an increasing number of older people and organised care to better meet their needs this included early memory loss documentation and they had a Mental health nurse that took responsibility for this register.

The practice provided regular ward round visits to the local care homes as part of a scheme initiated by the CCG. We saw that the GPs were visiting the care homes over and above this; often several times a week. The practice used a form called 'for you about you'; this contained information that will be useful for any other medical professions and contained the patients thought and wishes about the level of care they wanted to receive. Outcomes had been agreed to monitor the effectiveness of this document. For example reviewing the percentage of patients who had had a multi-disciplinary follow up assessment after admission to hospital. The document also stated what patients and staff in the care home should expect and promoted the best interests of the patient.

The practice had systematically implemented emergency health care plans, avoiding admission plans and do not attempt resuscitation (DNAR) to reduce burdensome interventions and unnecessary admission to acute care. We saw the information was evidence based and provided guidance to clinical staff. There was a register of vulnerable older patients who were at risk of admission to hospital. This was populated by internal practice discussion and use of a risk stratification tool. If older patients were at risk of admission, they had a care plan of on-going wishes and care needs. Patients then consented to relevant information being added to the OOH (out of hours) software system, so GPs could provide continuity of care. There was a monthly multi-disciplinary team (MDT) meeting to discuss the patients most at risk or those with on-going needs. The team also reviewed hospital admissions and discharges. Systems were in place to highlight any patients on this list and initiate an early GP review. The local care home said the GPs, without prompting, visited any patient who had been discharged from hospital.

Summary of findings

The practice used specific templates for the general older person health check that prompted a falls assessment, dementia screen, carer details and offered carers wellbeing/health checks.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nationally reported data showed that outcomes for patients were consistently high, for example for patients with diabetes. The practice had improved the patient pathway for diabetes management so it was a team approach and focused on holistic patient care. Nursing staff and GPs worked with patients to ensure jointly agreed care plans with patient-centred goals. Diabetes care included strategies to promote motivation and self-management. Patients with long-term conditions who were at risk were placed on the practice's avoiding unplanned admissions register. The most complex and at risk patients including those with end of life care needs were discussed at weekly practice meetings, in addition to the three monthly palliative care meetings, to ensure patients were closely monitored.

There were further recall systems for patients with chronic disease and treatment monitoring investigations for arthritis and long-term mental health. Patients on potentially toxic medicines or those taking medicines with side effects were offered regular medicine reviews. The dispensary team flagged up overdue medication reviews to the GPs who then organised reviews. The dispensary team also monitored for any over or under use of medicines which would then be communicated to the GPs.

Patients with long term conditions were reviewed following discharge from hospital. This was undertaken by the usual GP either by phone or visit. Appropriate information was uploaded to the out of hours GP system.

The practice actively promoted health education about long term conditions and encouraged self-help; they performed well line with CCG and national averages in all vaccination schemes.

The practice maintained an up to date carers' register, invited carers annually for a health check and linked them to the practice mental health nurse who also carried out a welfare and support role.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding 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.

Summary of findings

Immunisation rates were above CCG and national rates 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. Appointments were available outside of school hours. We saw good examples of joint working with midwives, health visitors and school nurses.

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.

The practice was proactive in offering online services for appointments and prescriptions and using technology to improve accessibility for this population group, for example text message reminders, cancellations and results. The practice provided a virtual patient participation group option for those who were unable to attend the meetings in order to capture the views of this population group. The practice offered a range of health promotion services including cervical screening, bowel and breast cancer screening and smoking cessation.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held registers of patients living in vulnerable circumstances including homeless people, adults at risk, children at risk, carers and those with a learning disability. It offered longer appointments for people with a learning disability,

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. The practice closely monitored vulnerable children. A nominated child safeguarding administrative and clinical lead attended child protection meetings. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

The practice recognised the need to provide extra support for marginalised groups and maintained close links with a local homeless shelter, delivering flu clinics for these patients and offered health checks.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

The practice had a higher than national and local incidence of mental illness. The practice employed a mental health nurse that managed her own case load ensuring continuity. Ninety seven percent of people experiencing poor mental health had received an annual physical health check and medication review.

Those deemed most at risk were placed on the avoiding unplanned admissions register and had collaborative care plans. Those at risk of medication abuse were put onto weekly prescriptions and the dispensary team kept a diary to ensure the prescription is collected before a new one is dispensed.

The practice was signed up to the dementia enhanced service. The practice had provided dementia training for clinical and non-clinical staff to improve awareness.

Summary of findings

What people who use the service say

The National GP Patient Survey results published on 4 July 2015 showed the practice was performing in line with local and national averages. There were 119 responses and a response rate of 40.3%. The evidence from this survey showed patients were consistently satisfied with how they were treated and cared for. Data from the survey showed the practice was consistently rated 'among the best' for its satisfaction scores on the service and consultations with GPs and nurses.

- 80% found it easy to get through to this surgery by phone compared with a CCG average of 65% and a national average of 74%.
- 93% found the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 86%.
- 66% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 89% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 95% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 84% described their experience of making an appointment as good compared with a CCG average of 70% and a national average of 74%.
- 58% said they usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 64% and a national average of 65%.
- 57% felt they didn't normally have to wait too long to be seen compared with a CCG average of 57% and a national average of 57%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. Reception staff, nurses and GPs were praised for their professional care and patients said they felt listened to and involved in decisions about their treatment. From the comment cards and the views of the six patients spoken with on the day of the inspection they told us that they were treated with compassion and that GPs and nursed went the extra mile to provide care when patients required more support. We also spoke with a member of the patient participation group who told us they could not fault the care they had received.

Areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The practice employed a mental health nurse that worked collaboratively with the GPs to develop mental health care plans. She held her own patient lists that were patients that had been referred to her by the GP. Patients could be referred directly into the mental health services, signed posted to support groups and receive support from the practice.
- The practice carried out a bi-monthly skin clinic ran by a GP with a diploma in dermatology. This GP liaises closely with the local Dermatology consultant and has reduced the number of hospital referrals by being able it identify and treat minor symptoms locally. Data showed that the practice referral rates to hospital were lower than national and CCG averages for skin legions.

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- The practice used a form called 'for you about you'; this contained information that is useful for other medical professions and contained the patient's medical history as well as their thoughts and wishes about the level of care they wanted to receive.
- The practice provided training and teaching to medical students and GP trainees, they also offered a placement to student nurses.

Sutherland Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and supported by a second inspector. The team included two specialist advisors, a GP and a practice manager.

Background to Sutherland Lodge Surgery

Sutherland Lodge surgery is located on the outskirts of the city of Chelmsford. The practice provides a primary medical service (PMS) to just over 12,000 patients of a diverse age group. The practice is a training practice for doctors who are training to become GPs, for junior doctors and medical students.

There was a team of four GP partners, three GP associates, one GP registrar and a GP trainee within the practice on the day of the inspection. Partners hold managerial and financial responsibility for running the business. There are four male and four female GPs. The GPs are supported by a practice manager, a mental health trained nurse, seven practice nurses, two health care assistants, a dispensary team, administration and office team.

Patients using the practice also had access to community staff including a community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.30am and 2.00pm to 6.20pm daily. Patients requiring a GP outside of normal working hours are advised to contact the 111 service and the call will then be allocated to the most appropriate service this service is used between 6.30pm until 8am Monday to Friday and from 6.30pm Friday evening through the weekend to 8am Monday morning.

The practice has a Personal Medical Service (PMS) contract and also offers enhanced services for example; timely diagnosis and support for people with dementia, memory assessments, dermatology clinic, influenza and pneumococcal immunisations as well as monitoring the health needs of vulnerable people with complex needs and learning disabilities.

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. This 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

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?

Detailed findings

• Is it responsive to people's needs?

• Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks 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)

We requested information and documentation from the provider which was made available to us before the inspection. This included;

- Information available to us from other organisations e.g. NHS England, Mod Essex CCG.
- Information from CQC intelligent monitoring systems.
- Patient survey information.
- The practice's training records

At the announced inspection on 14 October 2015, we:

- Observed how the practice was run and looked at the facilities and the information available to patients.
- Spoke to staff and patients.
- Reviewed management records.
- Observed interactions between staff and patients.

Good

Are services safe?

Our findings

Safe track record and learning

Openness and transparency about safety was encouraged throughout the practice. They prioritised safety and used a range of information to identify risks and improve patient safety. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events at partner and practice meetings but had not identified any themes. Cases were discussed in an open and non-judgemental way looking for lessons to be learnt to mitigate reoccurrence.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Medicines & Healthcare products Regulatory Agency (MHRA) alerts were reviewed by the senior partner who identified if a practice response is required. An example was discussed when an alert identified possible cardiac complications when two certain medications were prescribed. This alert was circulated to all clinical staff and discussed with the dispensary manager. Computer searches of patients' records identified who was on this medication combination and they were offered a review. To ensure this medication combination did not get prescribed routinely an alert notified GPs of the risks and considerations when prescribing the medication to promote safe and effective practise.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead member of staff for safeguarding was a GP partner who had undertaken extra training and all practice nurses were trained to the appropriate level; level three. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice website advising patients that nurses or trained administration staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).
- Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked two incidents and saw records were completed in a comprehensive and timely manner with appropriate action taken.
- There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- We observed the premises to be clean and tidy. We saw there were general cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.
- The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an

infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current guidance and legislation. All prescriptions for controlled drugs and medicines dispensed into blister packs were checked by a second dispenser. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. All dispensing staff had completed appropriate training and had their competency annually reviewed.
- The dispensing staff held a register of patients who required weekly prescriptions. These related to vulnerable patients identified by the practice due to potential risk of self-harm or failure/reluctance to take the medication as prescribed. The practice had systems in place to escalate concerns such as in the event a patient requests to take the prescription away. Whereby, the pharmacy contacts the chemist to request notification of collection before another prescription is produced the following week.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. 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. Staff told us this helped them to ensure appropriate actions were taken to minimise the chance of similar errors occurring again.
- All older patients on regular medication had an annual review of their health. This was prompted by their medication review date and followed up as a safety net by the dispensary team. The dispensary team alerted the GPs to patients who were over-due a review. Other patients were picked up opportunistically if they attended the practice.
- Recruitment checks were carried out and the four files we reviewed showed that 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.
- The practice explained that bank and agency staff were not used; staff provided cover for each other as they preferred to offer continuity of care for patients. There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were enough staff to maintain the smooth running of the practice and keep patients safe.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had 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. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was reviewed every month due to the detail and content. For example, contact numbers for each member of staff were recorded.

The practice had carried out a fire risk assessment in 2015 which highlighted no actions required. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Assessments and treatment of patients was in line with the National Institute of Health and Care Excellence (NICE) current guidelines. The practice had systems in place to ensure all clinical staff had been kept up to date and guidelines from NICE were used to develop how care and treatment was delivered to meet patient needs. For example, the latest NICE guidance for patients with raised cholesterol levels was being followed in terms of consideration for treatment with medicines. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

We were shown the person-centred, joint care planning template the practice used for diabetes patients as part of a local enhanced service. There was evidence of individualised goals, patient engagement and referrals onto other services where required. Staff could demonstrate that they had a thorough understanding of a physical and psychological needs assessment in patients with long-term conditions such as with diabetes and programmes of care incorporated motivational educational sessions to empower patients to meet their goals. Feedback from patients confirmed they felt the diabetes care provided was of a high standard. Eighty eight percent of diabetic patients had received an annual review in 2014/15.The practice had identified GP leads in specialist clinical areas such as end of life care, diabetes, heart disease and asthma and the practice nurses supported this work. One of the practice nurses had a special interest in diabetes and COPD and another practice nurse supported GPs with end of life care.

The practice was signed up to the national avoiding unplanned admissions enhanced service and also a locally agreed enhanced service which focussed specifically on the over 65s. The practice used computerised tools to identify patients who were at high risk of admission to hospital and automatically ensured housebound patients were on this register so that this specific group of vulnerable patients could have their needs met. Patients on this register had annual or six monthly reviews of their collaborative care plans, which we were shown, and a named GP acted as a co-ordinator for their care. We saw that after these patients were discharged from hospital they were followed up by a GP to ensure that all their needs were continuing to be met.

The practice was signed up to the enhanced service for dementia diagnosis and support they employed a mental health nurse to assist GP to manager this patient group. Patients with dementia received annual reviews and all patients who were due an annual review in 2014/15 had received one. The practice promoted dementia reviews on an annual recall system, unless they were identified as at risk patients on the unplanned admissions register where they received a collaborative care plan. The practice supported patients with mental health needs and reported they had a higher than national and CCG average incident of patients with severe and enduring mental health needs, as 0.94% of the practice population were on the mental health register for the practice. The practice had completed 67of the 69 annual reviews, which was 97% of patients on the register for 2014/15.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data from 01/04/2013 to 31/03/2014 identified the practice was running at 98% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 01/04/2013 to 31/03/2014 showed;

- Performance for diabetes related indicators was better than the CCG and national average. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 86.8% compared to the national average of 77.7%. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92.9% in comparison with the national average of 88.4%.
- All patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent which was better than the national average of 82.1%.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months better to the national average. The practice had an average of 92.1% in comparison with the national average of 88.6%.
- The dementia diagnosis rate was above the national average of 83.8%. The practice average was 85.7%.
- The local care home had been given a named GP for all patients to aid continuity of care. This GP visited weekly and on request. We spoke with the care home who were very complimentary about the prompt, caring and respectful service the practice provided.
- The practice supported 99% of their patients on warfarin by running their own anticoagulant clinic. This was introduced because it was identified some patients would have to use two busses to get to the local hospital. Now patients can be seen locally and quickly. Feedback to the practice from the comment cards and their own feedback forum 'I want better care' which is a web page patients were encouraged to post feedback about this service has been very positive.
- The GPs could refer patients the employed mental health nurse for memory and general welfare checks to ensure the patient was safe living independently. Patients would be given guidance and support as needed.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. There had been 14 clinical audits completed in the last two years, All of these were completed audits where the improvements made were implemented and monitored. The practice showed us all the clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, shared care patients (shared-care is when a GP supports and prescribes treatment for a patient which was initiated by a specialist. Implicit in a shared-care arrangement is that the patient continues to be followed-up in reviews by the specialist). The initial audit in 2014 identified 90% of patients requiring blood monitoring had attended a review and had their bloods checked. The re-audit in 2015 showed an improvement in monitoring patient bloods with 93% attending and have their bloods checked.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example two audit cycles had been carried out around the prescribing of a certain antimicrobial. The actions identified after the first audit indicated the practice was not meeting the required standard. The GP discussed antimicrobial stewardship with the antimicrobial pharmacist at the local acute trust to identify improvements. Discussions on how the practice may improve were put on the agenda for the practice meetings so all GP's were alerted to the changes. There was to be another audit in the near future to see if the improvements had been embedded.

Information about patient outcomes was used to make improvements such as; the practice appointed a mental health trained nurse who supported patients with mental health needs who were on the practice's mental health register. In addition to reviewing these patients on a recall basis the nurse acts as a resource for the GPs. They told us they refer patients to the nurse who may need more time to express their thoughts or where patients were showing signs of stress/not coping with their situations. The mental health nurse supports those with the most enduring mental health problems, which could include weekly meetings with the nurse and she had the ability to refer to the acute mental health units if required. Those deemed most at risk were placed on the avoiding unplanned admissions register and had collaborative care plans.

There was a register of vulnerable older patients who were at risk of admission to hospital. The practice identified vulnerable patients through internal practice discussion and use of a risk stratification tool. If older

patients were at risk of admission, they had a care plan of on-going wishes and care needs. Patients who consented, had their relevant information added to the OOH (out of hours) software system, so GPs could provide continuity of care. There was a monthly multi-disciplinary team (MDT) meeting to discuss the patients most at risk or those with on-going health care needs. The team also reviewed hospital admissions and discharges. The practice manager received a daily list of all their patients that were in hospital. They used this to identify when a patient was in for a long time or had been discharged. Systems were in place to highlight any patients on this list who had been discharged from hospital in order they received an early GP review. The local care home said the GPs visited any patient who had been discharged from hospital without prompting.

Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these. Practice nurses had all had advanced specialist training in asthma, diabetes coronary heart disease, chronic obstructive pulmonary disease, tissue viability and doppler ultrasound measurements. (A doppler ultrasound is a non-invasive test that can be used to estimate the blood flow through blood vessels identifying any restriction). Administration and office staff had developed their skills in order to perform various tasks within the practice so they were able to cover for sickness, annual leave or if the practice experienced a higher work load in a specific area.
- The mental health trained nurse at the practice had also undertaken training in hypnotherapy They used relaxation techniques to assist in the treatment of some conditions; this include most of the population groups for example a working age patient suffering work/life balance stress, or a new mother unable to relax due to the pressures of being a new mum, as well as patients suffering from emotional stress trying to cope with their long term condition.
- A GP partner had advanced training in dermatology and held a skin clinic bi-monthly enabling any GP to refer their patient. Audit results identified a reduced rate of hospital referrals over the past two years,
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff 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 their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and 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. Staff and services were committed to working collaboratively, people who had complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to people who used the services. The practice held an enhanced multidisciplinary team meeting monthly to discuss the most vulnerable patients and their care requirements. Professionals in attendance included a GP (on a rotational basis), the practice manager, the audit clerk (whose responsibility was to ensure correct coded information is documented in the patient's notes), community matron, a district nurse and a social worker. By

the end of the meeting a plan of action was identified with professionals, actions and requirements were documented for each patient discussed and the outcomes reviewed at the next meeting.

The practice held meetings with the health visitor and midwife to discuss any identified vulnerable patients including children in need and/or at risk, also any pregnant patients who may have or develop complications. By the end of the meeting a plan of action identified with professionals documented actions and requirements for each patient. The outcomes were reviewed at the next meeting.

Accident and Emergency attendance figures were relatively low at a score of 11 per 1000 patients compared to the national average of 14. Emergency cancer admission figures were similar to the national average at 7.7per 100 patients on disease register to national average of 7.1. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. The process for seeking consent to minor surgery was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

The practice used templates for documenting consent for specific interventions. For example, for childhood vaccinations verbal consent was documented in the child's electronic patient notes with a record of who gave consent and who was present at the appointment. Written consent was obtained for minor surgery procedures where the relevant risks, benefits and possible complications of the procedure were explained.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Patients who may be in need of extra support were identified by the practice. 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 and alcohol reduction. Patients were then signposted to the relevant service. A trained mental health nurse was available on the premises and was able to offer support to patients identified as suffering from stress.

The practice had a comprehensive screening programme. The percentage of women aged 25 to 64 whose notes record that a cervical screening test was required and had been performed in the preceding five years was 95%. This was above the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Childhood immunisation rates for the vaccinations given to under twos ranged from 95% to 100% and five year olds from 91% to 98%. These were above national averages.

The practice website contained information for patients for home care of various ailments, such as coughs and colds and information of external websites including Asthma UK, Cancer UK and fit for travel websites.

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

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a strong, visible, person-centred culture within the practice. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with respect. Relationships between patients, those close to them and staff were strong, caring and supportive. Staff worked hard to recognise and respect the totality of people's needs. They always took people's personal, cultural, social and religious needs into account.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey from July 2014 where 119 patients responded.

The evidence from this survey showed patients were consistently satisfied with how they were treated and cared for. Data from the survey showed the practice was rated 'among the best' for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% of respondents said the last GP they saw or spoke to was good at giving them enough time. This was higher than the local (CCG) average of 85% and national average of 87%.
- 97% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 96% of respondents said the nurse was good at listening to them compared to the CCG average of 90% and national average of 91%.

All of the 37 patient CQC comment cards we received contained positive comments. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a member of the Patient Participation Group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Patients repeatedly referred to the service as caring, respectful, exceptional, efficient and outstanding. Many comments included examples where the staff had gone above and beyond what was expected. For example:

- A prescription request from a patient had not given the dispensary time to order the medicines. The member of staff had got the prescription processed at another pharmacy five miles away and had delivered the medicines to the patient, who lived in an isolated area, in time for their next dose.
- A patient who suffered with a chronic condition that required frequent medical support told us they had received outstanding care from the GP and staff at the practice. They felt all staff went above and beyond the call of duty in assisting them to manage their condition.
- Dispensing staff monitored patients that were vulnerable to miss-using their mediation. Some patients were on a weekly prescription and the dispensing team monitored these patients referring back to the GP if they identified any issues for example if prescriptions were not being collected.

Patients also appreciated the friendly, professional, kind staff and said the facilities were clean and tidy. Patients referred to being very impressed, reassured and grateful for the attention and care they received.

Results from the National GP Patient Survey, July 2014 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% of respondents said the GP was good at listening to them compared to the CCG average of 87% and national average of 88%.
- 86% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 93% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.

Outstanding ☆

Are services caring?

- 93% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey, July 2014 we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 89% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 85% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.

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.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers with 131 patients identified as carers and were offered extra support by the mental health nurse or GP to ensure their health is kept at an optimum. This included sign pointing to support groups, ensuring timely access to appointments if they had caring duties that constrict their ability to leave home. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Carers were supported by the mental health nurse whose responsibility also included maintaining the carers register and contacting them for health check reviews and general welfare assessments.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer support and to answer questions, to minimise the distress and maintain ongoing relationships. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and if needed provide them with advice on how to find a support service. The practice had mental health nurse that was able to offer post bereavement support available in the practice.

The practice ensured that the named GP contacted patients with a new diagnosis of cancer to offer support to them and their families. Some patients when it was identified they were near their end of life were given the GPs mobile telephone numbers to facilitate communication, care and support of the patients.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and responded to patient needs. They attended locality meetings to connect with the local CCG engaging in the planning of services to improve outcomes for patients in the area. For example, they discussed dermatology services and identified a need to reduce referrals. The practice subsequently funded a GP to undertake a dermatology diploma who was then able to offer in-house dermatology clinics. This reduced referrals for patients to be seen at the local hospital.

The practice had an active patient participation group which held regular meetings. The meetings were attended by practice staff, where they discussed issues and linked in with members of other organisations such as Healthwatch.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice ensured Monday surgery was reserved for only same day appointments, as their audit had found this day to have peak patient demand.
- Urgent access appointments were available for children and those with serious medical conditions. All appointments on Mondays and 30% of appointments on Tuesdays to Fridays were held for urgent appointments only.
- There were longer appointments available for people with a learning disability and these patients were all offered a health check. These reviews were undertaken by an outside organisation.
- Home visits were available for older patients and housebound patients who would benefit from these.
- There were accessible facilities, baby changing facilities and translation services available.
- The practice had adapted the building to enhance access for those with disabilities (with ramp access to the building). Staff were also mindful of individuals needs and would arrange consultations to be held in ground floor rooms where the patients were unable to access the first floor.
- Phlebotomy services were available onsite for all patients.
- Walk in blood pressure clinics and urinary tract infection clinics were available, this saved patients waiting for an appointment.
- The practice employed a mental health nurse. Patients were able to book longer appointments and benefit from access to complementary therapies such as hypnotherapy without any cost implications. The nurse also maintained a register of patients with dementia, ensuring all dementia patients were invited to and received their reviews. This additional service was very well received by patients.
- The practice recognised and registered carers. The healthcare assistant (HCA) was the appointed lead and promoted health checks for this patient group.
- The practice made good use of language translation facilities as well as having multi-lingual staff to help when needed.
- The practice registered patients of no fixed abode, and offered them health checks.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.30am and 2.00pm to 6.20pm daily. 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 on the same day.

Results from the National GP Patient Survey, July 2014, showed that patients satisfaction with how they could access care and treatment was better than local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 79.3% of respondents were satisfied with the practice's opening hours compared to the CCG average of 71.4% and national average of 75.7%.
- 79.6% of respondents said they could get through easily to the surgery by phone compared to the CCG average of 64.7% and national average of 74.4%.
- 83.9% of respondents described their experience of making an appointment as good compared to the CCG average of 69.9% and national average of 73.8%.
- 94.7% of respondents said the last appointment they got was convenient compared to the CCG average of 92.1% and national average of 91.8%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We spoke with five patients on the day of our inspection who were all satisfied with the appointment process; they felt confident that they could access appointments by phone or online. We received positive feedback from the patients about the phlebotomy service, patient referrals and staff attitudes.

Listening and learning from concerns and complaints

The practice had a 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, the practice manager, who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system e.g. leaflets in the waiting area and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at the six complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and there was openness and transparency when dealing with the complaint. Verbal complaints were not documented and therefore themes could not be evidenced and learning shared.

Lessons were learnt from written concerns and complaints in an annual complaints review.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice was well organised. There were policies and procedures in place to govern activity and these were available to staff on the practice intranet on all practice computers. We looked at seven policies and saw evidence that they had been reviewed annually. Staff spoken with confirmed they had read them and use them when required.

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff spoken with confirmed they were aware of their role requirements and we were given a copy of the staff practice structure.
- There was strong leadership for all clinical and non-clinical areas such as monitoring patient experience of the quality of care and treatment. Patients benefitted from access to specialist care by GPs with hospital based experience and advanced qualifications.
- There was a system of reporting incidents without any fear of reproach and whereby learning from outcomes of analysis of incidents was actively shared.
- There was a programme of continuous clinical and internal audit which is used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Staff were supported to meet their professional requirements.For GPs this was revalidation and for nurses evidence of continuing professional updating.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The leadership team have an inspiring shared purpose, they strive to deliver and motivate staff to succeed. Staff told us that they enjoyed working at the practice and a number of nursing, administrative and reception staff had worked at the practice for a long time. Staff said they felt respected, valued and supported, and newer staff commented that they felt it was particularly well-organised.

When there were unexpected or unintended safety incidents:

• The practice gave affected people reasonable support, truthful information and a verbal and written apology.

• They kept written records of verbal interactions as well as written correspondence.

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

• Staff told us the practice held regular team meetings.

• Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did.

• The management team had bi-annual planning meetings to review progress with current plans and further development requirements.

• Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team.

The practice had also gathered feedback from staff 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. Staff told us they felt involved and engaged to improve how the practice was run.

The practice had supported GP registrars to successfully complete training for over 45 years. Trainees spoken with told us they felt the practice had offered them diverse learning opportunities and all GPs provided significant support.