

Lofthouse 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	Good	
Are services safe?	Good	
Are services effective?	Good	
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

We carried out an inspection of Lofthouse Surgery on 22 October 2014 as part of our comprehensive programme of inspection of primary medical services.

The practice is rated as good. The practice is well led by its partners, staff and the patient reference group. It is a practice that places the patients' needs and preferences at the heart of its services. Details of these findings are in the following report, but in summary our key findings were as follows:

- The practice is safe. Systems were in place to monitor patient safety. Staff were encouraged by the management team to be proactive in talking to them about incidents and concerns and helping to find solutions.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- The practice is effective. People received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to

ensure they were up to date with best practice.

According to the data from Quality and Outcomes Framework (QOF), an annual reward and incentive programme showing GP practice achievement results, outcomes for patients registered with this practice are above average.

- The service is caring. Patients reported overwhelmingly the positive view they had of the doctors and staff at the surgeries. Practice staff new their patients well. The service ensured people received accessible, individual care, whilst respecting their needs and wishes. The QOF indicators showed that patients felt listened to and involved in decisions about their care and this was better than other practices in the area.
- The service is responsive. The appointment system is guided by the needs and views of the patients. Urgent needs are addressed on the day and the patients in general are able to see the GP of their choice. The service has positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- The service is well led. The practice has a clear vision and set of values which are understood by staff and

Summary of findings

made known to patients. There is a clear leadership structure in place and quality and performance are monitored and risks are identified and managed. We found that practice ensured that its own internal processes for staff and performance management that are focused on patient outcomes and the quality of care for patients.

There are also several areas of outstanding practice and these include:

- The practice places its patients at the centre of its strategy and plans for the future. There is a clear sense of purpose and strategy that is shared by partners, staff and the Patient Reference Group. Patient statements and the access patients have to medical care and advice affirm the approach the practice is taking.
- Nursing and residential homes in the area enjoy a very positive relationship with this practice. The practice has ward rounds at the local homes so that older people can be seen frequently, effectively and efficiently.
- The practice has outstanding services for people who have learning difficulties and has taken the lead in the CCG and in the Leeds conurbation that is comprised of three CCGs. This ensures that people with learning disabilities have good access to medical care and advice. The practice is well engaged with the providers of care for people with learning disabilities.

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?

The practice is rated as good for safe. 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 to support improvement. Information about safety was highly valued and also used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. We found the practice had initiated service improvements for their patients that were over and above their contractual obligations. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Reference Group (PPG).

Patients reported good access to the practice and had a named GP or GP of choice promoting continuity of care. Urgent appointments were available on the same day. There was evidence of shared

Good



Summary of findings

learning from complaints with staff and other stakeholders. This was a patient-centred practice, where in the words of one partner if a patient said they needed to be seen that day they would be seen that day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

The practice is rated as outstanding for well-led. The striking feature of this practice was that it was clear that patients' preferences, needs and views were the factors that lay at the centre of the practice's concerns and service. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders, the patient reference group (PRG) and was reviewed and discussed with staff. There was good leadership and a strong learning culture. The practice responded effectively to change and encouraged staff to make suggestions for improvement. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. We found there was constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active PRG. All staff we spoke with felt valued and rewarded for the jobs they undertook. They were encouraged to develop themselves in terms of skills and undertaking new roles within the practice.

Outstanding



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

The practice is rated as good for the care of older people. The practice had established with the local nursing and care homes weekly rounds so that older people could be seen frequently so that their condition and well-being was effectively monitored. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits when requested or needed. Following a suggestion from the PRG the practice introduced an appointment reminder using mobile phones text messaging for older people and other patients.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured six-monthly reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Immunisation rates were high for all standard childhood immunisations. We were provided with good examples of ensuring the appropriate support was available to new mothers. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. All staff were well aware of their safeguarding responsibilities with respect to children and adults.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people. The needs of the working age population had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and other patients who were believed to be vulnerable.

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

The practice worked beyond its boundaries and patient list. An example of this was how the practice had taken the lead with respect to the needs of people who had learning disabilities. Not only had this affected the care they provided to people on their patient list, but it also involved the providers of residential care services, neighbouring practices, the CCG as a whole and the two other CCGs in the Leeds conurbation.

Outstanding



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Depression management is evidence based and responsive. There was safe prescribing of antidepressants and follow up is appropriate. All people with severe mental health problems who were identified through the QOF data receive annual physical health check.

Good



Summary of findings

What people who use the service say

We observed staff interaction with patients in the waiting areas at both surgeries, we spoke with six patients, two of whom were members of the patient reference group (PRG) and reviewed the report of the patient survey that undertaken late in 2013. We also considered the 33 completed CQC comment cards that were available at the Lofthouse Surgery. In summary patients were very positive about how the practice worked and met their needs.

- The practice's patient survey showed overwhelmingly that patients were content with the appointment system and felt they could access medical attention and advice when they needed.
- Patients we spoke with said they would recommend the practice to other people. They felt listened to and involved in their treatment. It was evident that patients felt the commitment of both staff and the doctors in that they would ensure that their healthcare needs would be met.
- Patients knew they could speak to someone in private if necessary and that they could have someone present during their consultation if this was what they wanted. All patients were happy with the cleanliness of the environment.
- Patients think of Lofthouse as a village and as with most villages people talk about the services and facilities in the village. Patients were aware that people were changing their preference for their GP practice so that they would be listed with this practice and they said this was not surprising as the practice enjoys a deservedly good reputation in the village. People talk about the practice in the village.
- The Patient Reference Group was an active group that was facilitated by the practice manager and one of the lead partners. It was evident that the PRG was active and had contributed to practice's strategy and feedback about patients views. They were listened to and had influenced practice policies with respect plans for reducing the number of "did not attend" appointments and risk management in the practice.
- Patients had made recommendations through the suggestion box and the patient survey and we saw examples when these had been acted upon.

Outstanding practice

There were also several areas of outstanding practice and these included:

- The clear sense of purpose and strategy for the practice that was shared by partners, staff and the Patient Reference Group (PRG).
- It was clear that patients' preferences, care and need were at the centre of the practices means of delivering services and this was shown through patient statements and the access patients had to medical and health care advice as well as their clear statement in the five year development plan.
- The practice had a very effective and positive relationship with nursing and residential homes in the area and had taken the initiative to set up ward rounds so that older people could be seen frequently, effectively and efficiently.
- The practice had outstanding services with respect to people who had learning difficulties and had undertaken the lead role influencing the care provided by neighbouring practices, with the CCG and with the other two CCGs covering the Leeds district.

Lofthouse Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team of four people was led by a CQC Lead Inspector and included a CQC second inspector, a GP, and a practice manager.

Background to Lofthouse Surgery

Lofthouse Surgery is located on the border of Leeds and Wakefield. It is comprised of two surgeries, the main one being Lofthouse Surgery and a smaller branch at The Manse which is located in Rothwell, Leeds. Both sites work with the same patient list which cover a population of over 10,000 people and it is a growing list particularly over the past two years. It has five GP partners (two female and three male) and the staffing arrangement is three fulltime GPs, two part-time GPs, a practice manager, a salaried GP, two practice nurses, two health care assistants and a team of administrative and domestic staff. The population they serve is primarily an older population with nearly of third of their list being over the age of 65 years and this appears higher than other practices throughout the country.

The branch surgery, The Manse is located at:

4 Marsh Street

Rothwell

Leeds

LS26 0AE

We visited both sites as part of this inspection.

The practice has a General Medical Services (GMS) contract with NHS England to provide primary care services in this area. The practice does not believe this is the appropriate contract arrangement as in their view the contract does not recognise the demographics of their patient list and the fact that is a rapidly growing list.

The practice was inspected in November 2013 under the old style inspection methodology when it was found to be non-compliant with respect to requirements for workers and as a follow up inspection in February 2014. It was found to be compliant with the regulations. The practice performs well on the quality and outcome framework (QOF), which is national performance measurement tool for GP practices. For five QOF indicators the practice performed better than other practices nationally. These indicators were about services for people with learning disabilities, two were regarding services for people receiving palliative care and support, and two were about patient satisfaction with respect to their doctor and nurse contact and their involvement in the decision making regarding their treatment.

The practice uses Local Care Direct 111 service to provider after hours responses for patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country. Lofthouse surgery is part of the Leeds South and East CCG and was randomly selected from the practices in the Leeds South and East Clinical Commissioning Group (CCG) area.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

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 in accordance with the Care Act 2014.

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.

How we carried out this inspection

Before inspecting this practice, we considered information we held about the practice and asked other organisations to share their views about the practice. We carried out an announced visit on 22 October 2014. During our visit we spoke with various staff including three of the GP practice partners, a locum GP, the practice manager, a practice nurse, administrative staff and six patients, including two members of the patient reference group for the practice. We observed how people were dealt with when they arrived at the surgeries.

The team met with the senior partners of the practice and the practice manager and the practice explained how they were structured, their aims, their achievements and changes over recent months and their current challenges. We explained how the inspection process worked and how

the information we collected would be used. In preparation for the inspection we had also spoken with the Leeds and South and East CCG, the West Yorkshire local area team of NHS England and Healthwatch, Leeds.

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

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

We also looked at how well services are provided for the following specific groups of people:

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

As noted earlier, the practice patient list showed that the proportion of people aged over 40 years was greater than other practices nationally, while patients under the age of 40 years, including children, was significantly below the average of other practices.

Are services safe?

Our findings

Safe track record

Systems were in place to monitor patient safety. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Staff were encouraged by the management team to be proactive in talking to them about incidents and concerns and helping to find solutions. Staff we spoke with were clear about the reporting systems in place for ensuring patient safety and were able to tell us about some of the incidents and concerns and what improvements had been put in place as a result.

All significant events were recorded on the IT system. The GPs told us they were a high reporter on the system but that this was because they wanted to capture all actual incidents and near misses. These were discussed at monthly clinical meetings and changes in practice and learning points were actioned and disseminated to other members of the team. We were told of an example whereby following one particular concern the prescription clerk now reviewed all hospital letters after GPs had seen them to ensure that medication alterations had been actioned on the patient's prescription chart. We saw their report of their significant events review for 2013-2014. We spoke with the practice manager about 11 of these events and looked at the actions taken as a result. We were told that the practice manager trains the reception staff to report any concerns to either a partner or to herself as practice manager. Our view of the of the process was that it was thorough and where there could learning and changes this occurred.

We were told about their effective system for regular audits and monthly meetings that examined clinical issues. The results of these discussions were minuted and distributed throughout the practice as needed. We noted that the practice manager ensures that staff do report any concerns to either her or a partner.

We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring. These were discussed at clinical meetings and any action to take was identified and recorded for follow up at subsequent meetings.

Patient safety alerts were immediately emailed to GPs by the practice manager. All relevant ones were printed off and

then brought to the clinical meetings for discussion and action recorded where needed. Any alerts specific to nursing were emailed directly to the practice nurses as well and the lead nurse ensured action was taken as required and any action documented. Clinical staff were able to verify this process.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

There was an open and transparent culture when accidents, incidents and near misses occurred.

There was an accident and incident reporting policy and procedure to support staff and with which they were familiar.

One of the GPs explained for instance there had been a concern about a letter that had not been actioned and this led to an incorrect dose of drug being administered. This heightened awareness of system failure. As a result a system of alerts on the patient records was devised. Another example concerned a dementia patient over-using paracetamol. These have led to changes to the communication from hospital and a new process for requesting painkillers from the desk.

The service had a process for monitoring significant events and when required these were reported to the local Clinical Commissioning Group (CCG) for further monitoring and scrutiny. The practice was benchmarked against a quarterly review undertaken by the CCG. We were given two examples of significant events around medicines misuse by individual patients where the practice had put in place a plan to prevent reoccurrence which showed very clearly the lessons learnt from the incidents. Another incident where a patient had been allergic to a particular medicine showed the immediate action the practice had taken to stop this medicine being taken by the patient.

Of the events we reviewed we were satisfied that appropriate actions and learning had taken place. All actions were monitored at monthly meetings for review to be sure any actions had been implemented.

There was an annual review of significant events to look at incidents through the year and review changes to see if those changes had been embedded in practice. The annual review included a review of patient complaints to look for themes and trends. To date no particular themes or trends

Are services safe?

have been identified. We were assured that once matters have been discussed at practice management meetings the relevant changes and actions are effectively cascaded to the clinical team.

Reliable safety systems and processes including safeguarding

There were comprehensive safeguarding policies in place for children and adults. Staff demonstrated knowledge and understanding of safeguarding and they knew who took the GP lead responsibility in this and had ready access to the CCG and Local Authority safeguarding contact numbers if they needed them. All staff spoken with said they would approach the lead GP or the practice manager if they had any safeguarding concerns. All staff had undertaken training regarding safeguarding of children and adults as part of their essential (mandatory) training modules. This training had been given at different levels appropriate to the various roles of staff.

The last training event on safeguarding was 12 months ago as part of a TARGET (Time for audit, research, governance, education and training) session. There was also an icon on the IT system that worked as a prompt and alert for clinicians in the event of a safeguarding issue emerging during patient contact. Clinical staff are aware of these arrangements. The practice was very aware of the implications and their duties with respect to the Mental Capacity Act 2005.

We were told that one of the partners took the lead on safeguarding matters and this included the training and liaison with health visitors. While there were no regular meetings with health visitors, when there were issues or problems there was effective liaison with these agencies and professionals.

There was a chaperoning policy in place. Nursing staff and health care assistants, who had been suitably trained, undertook the chaperone role when this was needed. However, on occasions administrative staff may also be called upon to do this. They too have received training in this regard. There was clear signage in the reception area offering chaperones if so desired by patients.

Medicines management

We found there were up to date medicines management policies in place and staff we spoke with were familiar with them. The medicines management review policy was detailed and clearly showed the responsibilities from the

request, to the production and authorisation of the prescription. There were clear clinical controls in place which included ensuring that medication changes following a patient's discharge from hospital were amended and authorised personally by the doctor in order to avoid errors. We saw that medicines for use in the practice were stored securely and that only clinical staff had access. Medicines were checked regularly and stock rotated, this ensured that medicines did not go past their expiry date and remained safe to use. The vaccine fridges we saw were well stocked but not overly stocked which showed that stock control was effective and medicines were not in danger of being wasted by going out of date before use. Fridge temperatures where medicines were stored were checked daily by the nursing team and they were familiar with what to do should the temperatures be outside the appropriate range. We saw the practice nurse preparing to take some vaccines to the branch surgery using a cold bag to ensure the continuation of the "cold chain" in order to prevent the vaccines becoming unusable through being stored at too high a temperature.

Clear records were kept whenever any medicines stocked by the practice were used. The records were checked by staff who reordered supplies as required. There are no controlled drugs stored on the premises. We saw that emergency medicines were stored safely yet accessible to staff when needed and were monitored to ensure they were in date and effective. Medicines were available for home visits. Systems were in place to minimise the risk of unsafe use or of medicines being used inappropriately. GP

bags held minimal in date stock and the GPs had a good rationale in place for their decisions to carry the particular drugs on home / emergency visits. FP10 prescription pads were stored securely in a locked cupboard and a note made of the prescription numbers before they were signed out to prevent misuse of the prescription pads.

The practice computer system was backed up on a regular basis to ensure that prescribing records and patient records were kept up to date. Medication reviews on patients were carried out regularly when either a block of repeat medication had come to an end, when patients attended the practice for monitoring of the condition that required a repeat medication or opportunistically if the patient attended with another condition. The practice computer system alerted clinicians that a review was required.

Are services safe?

The practice was a low prescriber of medication in comparison to other practices in the locality. They had reduced the costs of medicine further with increased usage, where possible, of generic (instead of branded) medicines. This is part of a focus across general practice on optimal use of medicines and this tries to ensure that patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines and ultimately the cost of healthcare to the NHS; and improve medicines safety.

There were also effective systems in place with respect to the Alerts for medicines, devices and patient safety. The practice managers brought these to the attention of the GP for action where appropriate.

Cleanliness and infection control

Both sites were clean and tidy. Feedback from patients indicated that the practice was always clean. We saw that the treatment rooms had appropriate flooring that enables effective cleaning and minimisation of risk regarding infection transmission. We saw that all toilet areas, patient toilets, were clean and the patient toilet also had nappy changing table. The system for recording the cleaning the arrangements and checks was also seen. The last audit of cleaning and infection control arrangements was done in September 2014.

We saw staff washing their hands on a frequent basis. Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons. We saw that hand wash, disposable towels and hand gel dispensers were also readily available for staff. Clinical staff told us they had completed training in infection prevention and control. All cleaning equipment is appropriately stored. We saw there was safe storage and disposal of clinical and non-clinical waste.

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff we spoke with told us that all equipment used for procedures such as smear tests and for minor

surgery was single use. Staff were not required to clean or sterilise any instruments and this reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Infection prevention and control procedures were in place which provided staff with guidance and information to assist them in minimising the risk of infection.

One of the GPs takes on the lead responsibility for infection control and has prioritised actions from this audit. All staff have had recent training and all new staff undertake this part of their induction. We spoke with one staff member who had only recently commenced work with the practice and the above arrangements regarding their induction was confirmed. The training provided is through an e-learning package that is comprised of an advanced version for clinicians and a basic version for non-clinical staff.

We saw evidence that staff had their immunisation status checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance. We saw that spillage kits for were readily available for staff to use in the event of blood or body fluid spillages and for mercury spillages.

We saw that the doctors' consultation rooms were well equipped, clean and well organised. Information about protocols and procedures were easy to access. There was also appropriate information available about the mental capacity. It was clear that the way this was all laid out so that practitioners would see these as effective aids in their decision making. In comparison to many practices this appeared to be very effective.

Equipment

The practice had systems in place to ensure annual inspection (due November 2014), calibration, maintenance and replacement of medical equipment and portable appliance testing. Suitable equipment which included medical and non-medical equipment, furnishings and fittings were in place. Staff confirmed they had completed training appropriate to their role in using medical devices. We saw evidence that clinical equipment was regularly maintained and cleaned.

Oxygen was available in the practice and oxygen cylinders were seen to contain adequate oxygen levels. The practice

Are services safe?

did not have a cardiac defibrillator. However, staff had been trained in resuscitation and how to use a defibrillator. One of the GPs told us they were thinking about whether to purchase one for each surgery.

Staffing and recruitment

The staffing and premises issues are usually undertaken by the practice manager. The practice manager has been instrumental in reviewing the staff structure and benchmarking themselves against other practices. It is the view of some staff that the practice is understaffed and also under-resourced.

The service had a recruitment policy in place. Appropriate pre-employment checks were undertaken and completed before employment, such as references, medical checks, professional registration checks, photographic identification and Disclosure and Barring (DBS) formally Criminal Records Bureau checks. Staff had generally worked at the practice for a number of years but we were able to confirm that all of the relevant checks mentioned above were in place for a relatively new member of staff.

We discussed staffing levels and skill-mix with the practice manager and looked at the staffing roster. Patients we spoke with confirmed they could get an appointment to see a GP or nurse when they needed to. The practice used the same locum whenever needed so she was familiar with the practice, the patients the staff and the policies and procedures. All relevant recruitment checks had been carried out. Staff were flexible by rotating between both surgeries when needed.

Professional registration checks were completed annually and all the GPs, the practice nurses and the practice

manager had up to date medical insurance liability cover. We saw evidence of the effective performance management of staff so that the quality of care provided to patients was maintained at a high level. It was shown, for instance, that when there was an issue with respect to a GP's performance some time ago, this had been handled well – minimising risk to patients as well as good staff management.

Arrangements to deal with emergencies and major incidents

There was a disaster recovery plan in place for the practice. This outlined how they would respond to emergencies and major incidents that might interrupt the smooth running of the service. Copies were kept on each site and off site to ensure it was available if required.

On the day of the inspection the fire service also attended the practice to assess their fire risk assessment processes. We were told by the fire officer that the practice's preparedness and risk assessments were outstanding. We saw and staff told us that they had attended fire safety training. We were told that there was weekly fire alarm testing, monthly emergency lighting tests and a recent fire evacuation practice in September had taken place.

We noted that the practice did have oxygen available in case of an emergency but had decided following training that they would not have available a defibrillator. Doctors carry only benzyl penicillin in their bags and use other drugs from the surgery when needed and these are stored in the treatment room.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patients who needed additional support and/or other risks associated with their age, health condition and personal circumstances were coded on the patient record system. We saw that the practice had undertaken two other clinical audits one concerning urinary tract infections and another on minor surgery.

We were told that the practice operated on the principle of evidence based medicine. At the regular clinical meetings new guidance and guidance that was accessible from the National Institute for Health and Care Excellence (NICE) was discussed. Peer review mechanisms within the practice ensured that clinicians worked on the basis of evidence based practice. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from NICE and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

We were told that the practice used risk management processes in order to alert GPs to likely deterioration of patient health conditions. The practice had identified that some two percent of their patients were considered to be at higher risk due to their health condition. These cases were discussed regularly in clinical meetings. Interviews with GPs showed that the culture in the practice was that patients were referred on the basis of need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

All indicators on QOF showed the practice to be operating within expected outcomes or better. With respect to services for people with learning disabilities and palliative care service the practice was performing significantly better than other practices. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for their patients.

We were told about clinical audits that had been completed in relation to prescribing antibiotics. As noted earlier the practice is a low rate prescriber of antibiotics. The practice was aware that some patients overused their prescribed medication. As a result a medication chart was developed by clinicians for these patients and held with reception desk. This enabled both the practice and the patient to be more effective in the management of their medication.

We were told about how the practice provided end of life care. The practice worked to the Gold Standard Framework with multi-disciplinary meetings held every six weeks. The lead partner GP knew the families well.

We were told about the CCG quarterly "MOTs" that were designed to evaluate the practice's effectiveness. The findings of these efforts were discussed at clinical team meetings and we saw the notes from the most recent one in June 2014. Audits were undertaken as a result and we saw evidence of two of these. One was undertaken by a health care assistant and looked at the process for registering of new patients. Another was undertaken six months ago by a receptionist and this looked at patient visit patterns and led to

the practice adopting a weekly ward round process by GPs for the local nursing homes.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included: clinical audit scheduling; safeguarding management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last 12 months. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. For example we saw an audit regarding the prescribing of antibiotics for respiratory infections and bisphosphonate prescribing in line with recent published evidence. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the impact of any changes.

Are services effective?

(for example, treatment is effective)

The team was making good use of clinical audit tools, clinical supervision and staff meetings to ensure the effectiveness of their practice. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

We were told about the training that was provided in-house and the appraisal processes. We noted that members of the practice have been revalidated and that the practice supports this process. All staff undertook annual appraisals which identified learning needs from which action plans were formulated. Staff interviews confirmed that the practice was proactive in providing training.

Clinical meetings were attended by partners and sometimes nurses if there were relevant agenda items. TARGET (Time for audit, research, governance, education and training) were in-house training sessions held 10 times per year and have covered CPR training, note-keeping and multidisciplinary work, and updating of policies. Some TARGET meetings involved the whole practice. In addition to this there were informal meetings. One of the doctors interviewed said he had been re-validated and that he and the practice wholeheartedly supported this process. There was also in house peer support and these discussions occur on a daily basis about patients and decisions. The practice reported also that the CCG peer review had been a helpful mechanism, through which they benchmark themselves against other practices in order to maintain and improve their services.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. All of the GPs had been annually appraised and either had been revalidated or were in the process of being revalidated. (This is a requirement for all GPs. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. To work as a GP they must be on the NHS England “performers’ list” and being on this list is dependent on being successfully revalidated.)

A locum pack had been devised and compiled for induction of locums. We spoke with a GP locum on the day of the inspection and they explained to us how the induction process worked. The locum reported that they

had effective back up and support from the practice. While the locum has not been involved in the practice meetings she reported that effective communication of changes was done through the IT system. Any changes that were the result of significant events were also well communicated through this system and the practice manager. It was reported that there was a very effective “open door” policy and this enabled the locum to get suitable and timely advice when needed. We noted also that the practice called upon this locum regularly and as a result the locum GP was aware of the patients, the practice and provided continuity of care.

We saw that practice had an annual appraisal process in place for its staff and there was evidence to show that the most recent round of appraisals had been completed in September 2014. We were told that one of the partners together with the practice manager undertook the annual appraisal process for all staff. We saw also a training matrix that was used to support the appraisal process. We spoke with one staff member who previously provided administrative support and who had wanted to become a healthcare assistant (HCA). Two years ago the person had the appropriate training and achieved National Vocational Qualification Level IV and now worked entirely in the new role of HCA. The appraisal, development and reporting processes was effective. We saw that appropriate processes were in place for the recruitment of staff with respect to training and checks with the Disclosure and Barring Service.

Working with colleagues and other services

The practice worked with the local nursing homes regarding patients who had dementia. There were effective processes for the management of correspondence from other services. The practice had a policy and we saw evidence of the process the practice used to receive hard copy letters about patients. This showed that that they had been read by the doctors or other appropriate clinical staff, recorded what action was required as a result, then scanned onto the patient’s record and the paper record was then destroyed. All staff understood the process and their respective roles in that process.

The practice worked with other service providers to meet people’s needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post.

Are services effective?

(for example, treatment is effective)

Out of hours services were provided by Local Care Direct using the NHS 111 call number. There were effective systems in place for instance in the management blood test results so that anything that was urgent or abnormal would be picked up promptly and responded to. There were also clear processes for the management of referrals to secondary care and the process for the management of the patient's care when patients were discharged. Attention was paid to the assessed risks to the patient. We were told that if patients for instance were in the "two per cent" group of assessed high risk, then there would be prompt follow up visit by the GP.

In common with other practices, Lofthouse Surgery was engaged with their flu campaign and winter planning. Extra out of hours clinics were planned and this was happening in discussion with other local practices.

Information Sharing

Systems were in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was usually easy to use.

An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling its requirements. While it was acknowledged for instance with respect to dementia that it was easier when there was a clear diagnosis the practice worked with other services such as Aire Court (a part of the Leeds and York Partnerships Foundation NHS Trust) particularly when major decisions were needed about the patient's care.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of their care plans. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and other decisions. All clinical

staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to work with children aged under-16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

We saw that the practice met all of its targets with respect to vaccinations and cervical cytology. Their bowel screening programme showed better performance than other practices nationally. All new patients have an NHS health check and this is undertaken by the health care assistant. In the event of health concerns being identified the GP was informed and these were followed-up in a timely manner. The practice actively promotes health programmes such as referrals to the "lets change" weight programme and/or the smoking cessation programmes. The practice was also aware of the needs of carers.

One of GPs had recently attended a local event in Rothwell that had been arranged by the agencies from the voluntary sector. The GP had been impressed by the range and extent of local support available and this has prompted better use of such organisations to support their patients.

We saw that there were many and appropriate leaflets on lifestyle information, screening opportunities and vaccination information in the practice's waiting areas. The practice's website also provided a very good range of the health information.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check.

Population Groups

Older People

- The practice had a very effective link with the local nursing and residential care homes. Ward rounds are an enhanced service and are done once a week. Some 25 patients were seen in one round.
- There was provision of a named GP for all patients over 75.

People with Long Term Conditions

- Patients were recalled through medication reviews.
- There were Structured six monthly reviews for various LTCs (e.g. Diabetes).

Are services effective?

(for example, treatment is effective)

- There was a system for risk assessing patients – that is identification of those at high risk of developing LTCs.
- There was evidence of multidisciplinary case management meetings for these patients.
- All patients with a long term condition had a named GP.

Families, Children and Young People

- All immunisation targets were met.
- Antenatal clinics were done at the surgery and child health surveillance is done by the GPs. Every new mum was called at home once the discharge summary is received and if there are problems a home visit will be arranged
- There was evidence of signposting of young people towards sexual health clinics.
- There was evidence of multidisciplinary team working (midwives, nurses, health visitors) and while these were not regular meetings between these agencies and the practice, referrals and meetings occurred as needed.

Working Age people

- The practice is responsive to the needs to working age people. The practice is open from 7am three days in the week. Both surgeries are open to 6pm each day. We saw that there were appointment slots made available to patients who worked. We saw that there was capacity for the practice to see these patients when needed.

People whose circumstances may make them vulnerable

- Learning disabilities – the practice has a comprehensive register that identifies most if not all people with learning disabilities in their area. There was an icon on IT home screen that prompts the need to consider reasonable adjustments to enhance their access to care. Annual health checks administration. The practice contacts the residential home and arranges a time for an assessment. They then send out a symptom checklist form that was brought in including a urine sample. The practice took a lead not only with respect to their area but also neighbouring practices and the CCG.

People experiencing poor mental health

- Depression management was evidence based and responsive.
- There was safe prescribing of antidepressants and follow up arrangements were appropriate.
- All people with severe mental health problems who are identified through the QOF data receive annual physical health check.

Are services caring?

Our findings

Respect, Dignity, Compassion and Empathy

We observed staff interaction with patients in the waiting areas at both surgeries, we spoke with six patients, two of whom were members of the patient reference group (PRG) and reviewed the report of the patient survey that was undertaken late in 2013. We also considered the 33 completed CQC comment cards that were available at the Lofthouse Surgery.

Our observations and discussions with patients confirmed that people were treated with respect and compassion. Patients, some of whom had been attending the practice for most of their lives, said they could not fault the practice. More than one person referred to area of Lofthouse as a village and like all small communities people talk about their services. Lofthouse Surgery was highly regarded and in the words of one of the PRG members it was not surprising that the practice's patient list was increasing dramatically. He believed that this was due to the way the practice provided its care to patients and as a consequence its good reputation.

The waiting area was clean and check-in arrangements at both the main surgery and branch were automated. There were staff pictures on display and effective notices throughout the waiting room. These included information about chaperone arrangements if needed, complaints, and other health promotion information. There was a disabled toilet facility and other toilets, all of which were clean.

We observed staff to be considerate of the patients' needs for privacy and if needed there was a separate room that could be used to afford the patient more privacy when explaining their needs to reception staff. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception

desk which helped keep patient information private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The report of the practice's patient survey completed in 2013 noted that almost (98 percent) all of the patients who responded to the survey (total number of survey respondents was 192) were content with the appointment system and felt they could access medical attention when they needed it and with whom they preferred to see, although at the same time understanding of the limitations of the practice. Similarly patients were happy about the opening times. In all aspects that the survey explored patients expressed approval and support. The surgery was accessible and people felt they were treated with respect and dignity, listened to and that clinical staff communicated clearly and effectively. Patients were confident about the treatment they received. Free text comments in survey from patients showed that the practice responded to some suggestions such as having a photograph board of the doctors and staff at the surgery. Other comments made some suggestions about making improvements with respect to appointments, parking arrangements, about being told when doctors are running late and that the carpet in the waiting area needed cleaning. It appeared the practice took these suggestions on board and had responded accordingly. The practice produced a report of the survey that showed the results and concluded with a table headed "You said - We did".

This is consistent with the views on the NHS Choices website, which shows this practice was amongst the best in the country.

Patients we spoke with on the day said they would recommend the practice to other people. They felt listened to and involved in their treatment. Patients felt that the practice was efficient and with respect to two patients, who said they had a long term condition, had regular follow-up and this was managed well and with sensitivity.

Patient feedback on the vast majority of the completed CQC comment cards similarly reflected very positive statements about the practice and the way they have

Are services caring?

interacted with both clinical and reception staff. People have said that they have sufficient time in consultations, that felt listened to and supported by staff. Two patients noted that the practice had managed their long term condition from diagnosis through to on-going support and treatment very positively.

Patient/carer support to cope emotionally with care and treatment

Locum staff reported that the entire practice was entirely focused on the needs of patients. This was demonstrated

by reception staff and medical staff alike. There also seemed to be good access for patients and this was reflected in some of the feedback that the locum had had from patients themselves. As noted above the patient survey showed that people felt they were helped in a supportive and caring manner by both the clinical and reception staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs.

We found the practice was responsive to patient's needs and that it had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. As noted earlier, the practice had been proactive and assessed the risks to their patients and had identified two per cent of their patients who may develop further difficulty in their health condition. These patients were followed-up regularly and their needs reviewed.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was responsive to patient feedback. Examples we noted included the practice's responses to the arrangements in the waiting areas, furnishings and the installation of a photo-board in the waiting area showing the staff of the practice. Another example was about the practice's long standing problem with respect to patients who failed to attend after making an appointment (DNAs). This was costly in terms of time and effectiveness for patients. The patient reference group (PRG) noted this problem and questioned the practice about their presumption that patients, particularly older patients, were not familiar with information technology or mobile handsets. They suggested that they could obtain patients' contact details by email or mobile phone and remind people of their appointments on the day of the appointment. It appeared that this has been very successful. Since implementing the plan the PRG has noted a month on month gradual reduction in DNAs.

There has been very little turnover of staff over recent years which has enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them, including appointments with a named GP or nurse. The practice worked with local care homes and had a weekly ward round for residential patients at three care homes. We were told that other care homes wanted their patients added to the practice's list and this was understandable and commendable as care staff were not required to make appointments for medication changes or set up routine appointments for apparently minor issues. The impact of

this approach was seen in the reduced need for unplanned call-outs and reductions in unplanned admissions to hospital. The practice had achieved and implemented the gold standard framework for end of life care. They had a palliative care register.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For instance, one of the GP partners took the lead on learning disabilities. She ensured that all people with learning disabilities were contacted to help ensure that their health needs were met. This partner also took the lead with the CCG on learning disability issues. She had developed a "ready reckoner" for common conditions associated with learning disability. The template had been taken up by the CCG and there were easy read leaflets on the website also in use. The practice had also looked at the this group of patients with respect to "do not attend" appointments. The learning disability register was cross-checked in order to help people with learning disabilities through the health care system. The lead partner also assisted other practices with advice about setting up their own services.

This was very commendable as the lead taken by this practice has influenced the care provided by neighbouring practices and also in the other CCGs.

Access to the service

We saw the practice's appointment system and this was flexible enough to cater for patients' varied circumstances. For instance, for people who worked there were early morning appointments available.

Interestingly the practice has debated for some time about how to make best effective use of doctors' time in response to patient need and demand. We were told that the practice had considered using triage and telephone consultations in an endeavour to manage patient demand. However, they concluded that the time was best spent in seeing the patient, even if this amounted to simply reassuring the patient of how their condition might progress. The practice stated quite clearly if the patient felt they needed to be seen

that day, then they would be seen that day. In the practice's view this was simply one element of their "patient centred" service.

Appointments were available from 7am to 6pm on Tuesdays at The Manse Surgery and Wednesdays and

Are services responsive to people's needs?

(for example, to feedback?)

Thursdays at the Lofthouse Surgery. On the other days both surgeries were open from 8am through to 6pm. It was evident that these early appointment times were taken up by patients with work responsibilities. The practice said they were exploring how they could develop more comprehensive extended opening-hours arrangements with other practices locally.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was available to patients.

The consulting rooms were situated on the ground floors of both buildings although at The Manse Surgery there was a room that was used on the first floor. There was wheel chair access at both the Lofthouse and Manse Surgeries. We saw that the waiting areas was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

We looked at various sources of information on how the practice dealt with complaints. This included the provider's self-assessment and the practice's policy and procedure for managing complaints and their public information about this. We spoke with staff and patients about this also.

Patients were aware of the process for making a complaint. We saw that the practice actively encouraged patients to make suggestions and comments using the a suggestion box in the waiting areas. We noted that this was also evident from the statements of the people we spoke with, that is the patients of the practice and the members of the PRG.

Complainants had a single point of contact and this was usually the practice manager. While the practice preferred to deal with patients directly they were aware of the Leeds advocacy services and this was generally offered to complainants. Patients were not always aware that these services were available. The practice has considered the needs of people whose circumstances make more vulnerable and ensured for instance that there were easy-read documents about complaints available. We could see that complaints were managed efficiently, directly and effectively. Complaints were discussed at staff meetings and this was noted in the response to the complainant.

We saw that information was available to help patients understand the complaints system a summary leaflet was available in the waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

Are services well-led?

Outstanding



(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 and positive vision for the future and had developed a five year strategic plan showing the direction of the practice. The practice's purpose was, "...to provide excellent, safe, rewarding and person centred care and support to our patients". They aimed to achieve this by continually developing and maintaining a content and sound practice which was responsive to the needs and expectations of the population and which reflected whenever possible, the latest advances in primary health care. These aims were strongly visible in the discussions we had with the clinical and non-clinical staff at the practice, the patients and the members of the patient participation group.

The practice was considering refurbishment of their main surgery within their five year plan which would involve restructuring the practice. The management team had discussed their early initial plans with all staff and they were involving them in moving the practice forward. The draft plan was to be discussed in full at the next business meeting on 23 October 2014 and was to be shared in full with staff and comments and feedback invited afterward.

The strategic plan was written to respond to the challenges of increasing patient numbers. It had been developed in draft form by the practice managers and one of the lead partners. It had been agreed with the partners and the patient reference group (PRG).

Strategically the practice was looking beyond its own patient list. Its work with respect to learning disabilities was an example of this as the work that has begun here is being taken up with the CCG and neighbouring practices through the leadership from this practice. Furthermore one of the partners is undertaking leadership course with the CCG in order drive forward changes throughout Leeds.

The practice's strategic plan had been agreed with by all doctors and the plan is to increase staffing and enhance the building in view of their ever increasing patient list size. They realised that some of this increase is coming from patients who previously attended neighbouring practices. It is evident from both the list and the patient comments that the practice enjoys a very favourable reputation.

The practice displayed the values of the medical and health professions that may be regarded as traditional – that is a

service that was patient focused, aimed at attaining the highest standards of care and one that was accessible. It provided this service in the context of a continually changing health and social care environment, with increasing demands from both patients and other stakeholders. Their strategy and means of engaging people through the PRG and the CCGs demonstrated that this practice was outstandingly well led.

Governance arrangements

The practice had in place leads for key areas such as clinical audit, learning disabilities, infection prevention and control (IPC), medicines management and safeguarding and staff were able to tell us who the relevant leads were. From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from various sources, incidents, complaints and audit to identify areas where improvements could be made.

The practice adopted a culture of transparency and openness and all staff were clear about roles and responsibilities. All staff spoken with said the management team supported and valued them and that they were encouraged to feedback any concerns that they might have.

There were robust arrangements in place to identify, record and manage clinical and non-clinical risks and to share problems and the solutions to enable positive learning across all areas in the practice. To date a private provider has been commissioned to assess "risk" for the practice. A member of the patient reference group (PRG), whose own work involved assessing organisational risk volunteered his services to undertake this role in the future. This was another example of how well engaged this practice was with their patient group.

The practice reported its performance on the Quality and Outcomes Framework (QOF) on a quarterly basis to the CCG. The QOF data for this practice showed it was performing in line with national standards and in addition five areas were identified where they are performing better than other practices. These concerned services to people with learning disabilities, services for people receiving palliative care and support, and better than average patient satisfaction rates with respect to their doctor and nurse contact and their involvement in the decision making regarding their treatment.

Are services well-led?

Outstanding



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

We saw that QOF data was regularly discussed at clinical team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The practice had in place a programme for monitoring all aspects of the service provided. We saw that a number of staff had undertaken audits relating to their individual areas of practice. We saw evidence that improvements in practice had taken place as a result and that regular review of the improvements had been undertaken to ensure the effectiveness of the audit results which showed that the audit cycle had been completed. Where the audit cycle was not due for completion a date had been planned to complete it and close the audit loop. Examples of some of the audits undertaken included unplanned admissions, earlier diagnosis of cancer referrals, bisphosphonate prescribing and antibiotic prescribing.

We heard verbal and saw written evidence of effective multidisciplinary team working with, for example six-weekly reviews of patients on the end of life pathway at Gold Standard meetings and regular review of patients who were frequent attenders at the hospital accident and emergency (A&E) with care plans in place to anticipate deteriorating health problems earlier in order to prevent the need for the patient to attend A&E.

The practice submitted governance and performance data to the CCG. We saw evidence that the GPs, practice manager and nurses attended CCG meetings where performance and quality were discussed. The practice manager regularly attended Practice Manager meetings and was an active member of the Federating Group and the Action Learning Group feeding in and feeding back information to benefit the practice.

We saw from minutes that team meetings were held every two months. It was evident that these arrangements have been in place since 2012. The meetings are used to discuss practice development issues such as the recently produced five year plan. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with both senior staff/partners and at team meetings.

We spoke with the practice manager who explained that she has established herself in the role over the past 18 months. She is now working with the GPs in developing the practice. As noted earlier we saw their five year plan. The

practice manager is also involved in an action learning set that draws on the experience and expertise from neighbouring practices. There was also evidence of an open staff culture. Staff meetings were held every two months and we saw minutes of these meetings going back to May 2012. These arrangements were reviewed by the senior partners and the practice manager each September.

Staff felt supported in their roles and were able to speak with the practice manager at any time. They also said they would be happy to speak with any of the GPs if they felt they had concerns. Individual responsibilities were given to each member of staff and opportunities for progression were evident. As noted earlier we saw that one staff member who was previously a member of the practice's administrative support team was encouraged and supported through training to become a health care assistant. Staff felt valued and were rewarded for the good work they provided.

Practice seeks and acts on feedback from its patients, the public and staff

The atmosphere at the practice was open and suggested an open culture within practice, between staff members and between patients and staff. The practice had an established Patient Reference Group (PRG) and posters were displayed in the waiting areas and there was information on the practice website encouraging patients to become involved in the PPG. We found that the practice was actively encouraging patients to be involved in shaping the service delivered from the practice. It was evident that the role of the PRG is becoming more central as a means of driving improvements within the practice. One of the senior partners and practice manager facilitated this group. We spoke with two members of the PRG who were very supportive of the practice.

The practice was very open to suggestions for improvement from patients. There was a suggestion box in the reception area and we saw they carried out regular patient surveys. The last patient survey was done in 2013 and reported overwhelmingly satisfaction with the practice from 192 patients who responded. The practice reported the survey results in early 2014 and this showed that it had responded to patient suggestions from the survey and these included replacing the carpet in the waiting area, having a photograph board of the doctors and staff at the practice in the waiting areas and more flexibility about appointment systems. Patients were encouraged to

Are services well-led?

Outstanding



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

provide feedback through the practice website. The practice manager had been trained in the use of the NHS Friends and Family test questionnaires and these were due to be commenced in December 2014.

Staff told us they were able to contribute to the shaping of the practice and all suggestions however small were considered. Staff stated they were able to freely raise concerns with any of the management team or the doctors without any risk of recrimination. All staff spoken with said that they loved working at the practice, the team were always supportive and flexible and the doctors were fantastic always going out of their way for the patients and staff.

Locum staff also reported that in view of their experience in other practices and feedback from patient that there was good access to care. As noted earlier that while the locum did not necessarily attend practice meetings they were aware of the strategic issues facing the practice and they were kept up to date about the developments and the changes the practice was making. This was noted as being unusual when compared with statements from locums from other practices.

We spoke with two members of the patient reference group (PRG) who had been respectively involved with the group for two years and the other for past three months. Both spoke glowingly about the way the practice was run. They highlighted that there was good access to medical care, a flexible appointment system and a follow up system that ensured that people with long term problems would be regularly reviewed. They felt the practice was responsive to suggestions and cited an example where one of PRG members was alarmed at the rates of people not attending their appointments (DNAs). As noted earlier it had been suggested by the PRG that contrary to the popular myth that older people do not use new technology, that the practice might remind people of their appointments through text messaging to patients' mobile phones. This was taken up by the practice and in subsequent months they have seen a gradual, but significant month on month reduction in DNAs – an outcome that is good for the both patient and the practice.

The practice has to date used a private provider to assist them in assessing risk within the practice. However, this is likely to change. A member of the Patient Reference Group now retired was previously a risk assessor and has now offered his expertise to assist the practice. We saw the health and safety file held by the practice and this showed evidence of the various audits undertaken with respect to most systems in the practice, including fire safety and a recent fire drill. As noted earlier on the day of the inspection the fire service also visited the practice to assess their preparedness for such an emergency and this as being outstanding.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction as did any locum staff. We saw that all clinical and non - clinical staff attended time out of the practice in a protected learning time session known as 'TARGET' sessions 10 times a year. Five of these sessions were held external to the practice and five were in-house training sessions. Multidisciplinary meetings were held and included practice clinical staff, district nurses, the end of life team, mental health services and health visitors.

Staff we spoke with could explain how they had improved the services following learning from incidents, complaints and audits and told us that these were discussed at staff meetings and clinical meetings so actions and lessons learned could be shared. The meetings were documented and disseminated to staff who had not been present at the meetings. We saw evidence of a sample of these minutes.

There was a programme of induction, training and development for all staff. Mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific role. Staff were supervised and appraised annually to help identify their training and development needs to ensure they were suitably skilled and competent to undertake the job they were doing.