Dr P J P Holden & Partners

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 08 October 2014, as part of our new comprehensive inspection programme. The practice had not previously been inspected.

We found the practice to be good in safe, caring and responsive areas we inspected, and outstanding in effective and well-led. The overall rating is outstanding.

Our key findings were as follows:

Patients expressed a high level of satisfaction about the care and services they received.

Systems were in place to keep patients safe and to protect them from harm.

Patients were asked for their views, and their feedback was acted on to improve the service.

Patients were treated with kindness, dignity and respect.

The practice worked in partnership with other services to meet patients' needs in a responsive way.

Staff were supported to share best practice, acquire new skills and further develop their knowledge to meet patients' needs and provide high quality care.

The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet patients' needs, and drive continuous improvements. The leadership and governance arrangements also ensured the delivery of high-quality person-centred care.

We saw several areas of outstanding practice including:

The practice had links with local schools and had provided several presentations to pupils about health issues. Pupils from a local school had designed the new logo for the practice.

The leadership enabled staff to drive continuous improvements and carry out lead roles and innovative ways of working to meet patients' needs. For example, the community matron regularly visited patients in their own home and local care homes in response to their needs, and held quarterly meetings with the practice manager and care home managers to review their needs.

Summary of findings

The practice provided medical support to a local drug misuse service, and was helping to change perceptions about people who had a drug dependency**.** The practice worked pro-actively with relevant services, which had enhanced their safeguarding links and holistic approach to supporting families and patients who had a drug dependency.

The Patient Reference Group were actively involved in recruiting senior staff including the current practice manager.

In addition the provider should:

Complete a competency assessment to evidence that the health care assistant has been assessed competent to carry out specific health checks and delegated tasks.

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 safe. Patients told us they felt safe when using the service.Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Systems were in place to keep patients safe and to protect them from harm. Safety issues were recorded, monitored and reviewed. Lessons were learned and communicated widely to support improvement. There were enough staff to keep people safe. Arrangements were in place to ensure that the practice was clean, safe and well maintained.

Are services effective?

Outstanding

The practice is rated as outstanding for effective. There was a holistic and pro-active approach to meeting patients' needs which was driven by all staff at the practice. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. Patients were regularly reviewed to assess the effectiveness of their care and treatment. The services were very effective as all staff had clear roles in monitoring and improving outcomes for patients, resulting in a practice wide approach to care and treatment. Completed clinical audits were used to monitor, measure and improve the care and outcomes for patients. Staff worked in a proactive way and in collaboration with partner health and social care services to meet patients' needs. The practice had an established and experienced staff team, with a wide range of skills to enable them to deliver effective care and treatment. Staff were supported to share best practice, acquire new skills and further develop their competence and knowledge to meet patients' needs and ensure high quality care.

Are services caring?

Good

The practice is rated as good for caring. Patients described the staff as friendly and caring, and said that they felt that they treated them with respect and dignity. Patients were involved in decisions about their health and treatment, and received support to cope emotionally with their care and condition. We saw that patients' privacy, dignity and confidentially were maintained; staff were respectful, polite and friendly when dealing with patients. The practice was recently awarded a Carers Pledge and was due to complete a bronze dignity award, in recognition of their commitment to ensuring that carers feel valued and are treated with dignity and respect.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for responsive. The appointment system was flexible and was regularly reviewed to enable people to access care and treatment when they needed it. The practice worked in partnership with other providers and organisations to meet patients' needs in a responsive way. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients concerns and complaints were listened and responded to and used to improve the service.

Are services well-led?

Outstanding 

The practice is rated as outstanding for well-led. Patients were asked for their views, and their feedback was used and acted on to continuously improve the service. The culture, leadership and governance arrangements were robust and ensured the delivery of high-quality person-centred care. A clear business plan was in place, which set out the plans for future development and demonstrated a commitment to ongoing improvement. Regular meetings were held to discuss the business, finances, governance and performance. The systems for driving improvements and monitoring the quality of care and services had been strengthened. Robust processes and systems were in place to ensure that the service was well managed, and for identifying and managing risks. There was strong teamwork, leadership, and commitment to improving the quality of care and people's experiences amongst all members of practice staff. There was a very open, positive and supportive culture. There were high levels of staff satisfaction and engagement. The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet patients' needs, and to drive continuous improvements. All staff had clear roles and responsibilities to ensure that the practice was well led. There was an active approach to seeking out new ways of providing care and treatment.

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. Patients 65 years and over were offered an annual health check. All patients 75 years and over had a named GP to offer continuity of care to ensure that their needs were being met. Health care plans were provided for patients over 75 years, to help avoid unplanned admissions to hospital. Carers were identified and supported to care for older people. Home visits were carried out for elderly housebound patients.

The practice part funded a community matron's post who supported elderly patients and those with complex needs, to prevent avoidable admissions to hospital and improve outcomes for patients. The community matron regularly visited patients in their own homes and local care homes in response to their needs, and reviewed and referred them to ensure their needs were being met. They also helped the care home staff to complete appropriate assessments and care plans for patients, and provided advice and support to develop staff's knowledge and skills. The community matron and practice manager also held quarterly meetings with the care home managers to review developments relating to patients' needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. All patients were offered an annual review including a review of their medication, to check that their health needs were being met. When needed longer appointments and home visits were available. Where possible, clinicians reviewed patient's long term conditions and any other needs at a single appointment, to prevent them from attending various reviews. Emergency processes were in place and referrals were made for patients that had a sudden deterioration in their health. For those people with the most complex needs, a named GP worked with relevant health and care professionals to deliver multidisciplinary support and care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. The practice worked in

partnership with midwives, health visitors and school nurses. Appointments were available outside of school hours to enable children to attend. The practice worked with local schools to provide education on health issues and to promote their involvement.

Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of the working-age people (including those recently retired and students). The practice provided extended opening hours to enable patients to attend in an evening or early morning. Patients were also offered telephone consultations and were able to book non urgent appointments around their working day by telephone, on line and using the 24 hour automated service. The practice offered a 'choose and book' service for patients referred to secondary services, which enabled them greater flexibility over when and where their test took place. NHS health checks were offered to patients over 40 years. The practice was proactive in offering health promotion and screening appropriate to the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients with a learning disability were offered an annual health review, including a review of their medication. When needed longer appointments and home visits were available. The practice was part of a local scheme to support the most vulnerable patients with the aim of managing their needs at home and avoiding unplanned hospital admissions.

The practice worked with multi-disciplinary teams in the case management of people in vulnerable circumstances and at risk of abuse. The practice provided medical support to a local drug misuse service, and provided a holistic approach to supporting families and patients who had a drug dependency.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health. The practice held a register of patients experiencing poor mental health. Patients were offered an annual health, including a review of their medicines. The practice worked with multi-disciplinary teams in the case management of people

experiencing poor mental health, to ensure their needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access emergency care and treatment when experiencing a mental health crisis.	

Summary of findings

What people who use the service say

During the inspection, we spoke with nine patients including two members of the Patient Reference Group (PRG). The PRG includes patient representatives who work with the practice to improve the quality of care and services. Prior to the inspection, CQC received seven comment cards from patients. We also spoke with the managers of three care homes (for older people and younger adults with learning disabilities) where patients were registered with the practice.

Patients and representatives we spoke with felt that the practice was well managed. They expressed a high level of satisfaction about the care and services they received.

Patients considered that the premises were clean, and that the facilities were accessible and appropriate for their needs. They also said that they felt safe and listened to, and able to raise any concerns with staff if they were unhappy with the care or the service. They knew how to make a complaint. Patients described the staff as friendly and caring, and said that they felt that they treated them with dignity and respect.

Patients told us they were involved in decisions about their care and treatment, and were satisfied with the care and service they received. They were promptly referred to other services and received test results, where appropriate. However, several patients said that they did not find it easy to get through to the practice by phone or access appointments at times. In response to feedback, records showed that the practice had made changes to the telephone and the appointment system to improve access for patients.

Three care homes we spoke with praised the support staff received from the practice, and the care and service patients received. They said that patients were promptly seen and their needs were regularly reviewed.

Representatives of the PRG told us they worked in partnership with the practice. Patients were asked for their views, and their feedback was acted on to improve the service. The PRG carried out a patient survey in 2013, which 148 patients completed. 90% of those surveyed said that they would recommend the practice to their friends and family, and 63% said that they were generally very satisfied with the care.

We looked at the 2014 national GP survey, which 144 patients had completed. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services. Areas where the practice scored highest included the involvement of patients in decisions about their care, treating patients with care and concern, and patients overall experience of the surgery was good. Areas for improvement included access to appointments, getting through to the practice by phone and waiting more than 15 minutes to be seen.

The practice had completed an action plan to address areas requiring improvement in regards to the above surveys.

Areas for improvement

Action the service SHOULD take to improve

Complete a competency assessment to evidence that the health care assistant has been assessed competent to carry out specific health checks and delegated tasks.

Summary of findings

Outstanding practice

The practice had links with local schools and had provided several presentations to pupils about health issues. Pupils from a local school had designed the new logo for the practice.

The leadership enabled staff to drive continuous improvements and carry out lead roles and innovative ways of working to meet patients' needs. For example, the community matron regularly visited patients in their own home and local care homes in response to their needs, and held quarterly meetings with the practice manager and care home managers to review their needs.

The practice provided medical support to a local drug misuse service, and was helping to change perceptions about people who had a drug dependency**.** The practice worked pro-actively with relevant services, which had enhanced their safeguarding links and holistic approach to supporting families and patients who had a drug dependency.

The Patient Reference Group were actively involved in recruiting senior staff including the current practice manager.

Dr P J P Holden & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team included two CQC inspectors and regional GP advisor, a GP and a GP practice manager.

Background to Dr P J P Holden & Partners

Dr P J P Holden and Partners provide primary medical services to approximately 8, 300 patients in the Matlock area of Derbyshire. The practice has a higher percentage of patients aged 60 to 79 years. The range of services provided include minor surgery, minor injuries, family planning, maternity care, blood testing, vaccinations, mental health, drug and alcohol services and various clinics for patients with long term conditions.

The practice is a training practice for doctors in training. It is managed by Dr P J P Holden and Partners. It employs 11 administrative staff, a practice manager and an assistant practice manager. The clinical team includes four partners and two salaried GPs, a community matron and a nurse practitioner, three practice nurses, a phlebotomist and a health care assistant; four staff members are males. The practice opted out of providing the out-of-hours service.

The practice holds the General Medical Services (GMS) contract to deliver essential primary care services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. The practice had not previously been inspected and that was why we included them. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also spoke with two health care professionals who worked closely with the practice and staff at the local minor injuries unit.

We carried out an announced visit on 08 October 2014. During our visit we checked the premises and the practice's records. We spoke with various staff including, two practice nurses, the community matron and nurse practitioner, a health care assistant, four GPs, reception and clerical staff, the practice manager and assistant practice manager. We also received comments cards and spoke with patients and representatives who used the service.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Detailed findings

- 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)

Good

Are services safe?

Our findings

Safe Track Record

Patients told us they felt safe when using the service. Records showed that safety incidents and concerns were appropriately dealt with. Risks to patients were assessed and appropriately managed. A system was in place to ensure that staff were aware of national patient safety alerts (NPSA) and relevant safety issues, and where action needed to be taken. NPSA are managed by a central alerting system in England, which forwards information about safety incidents to all NHS organisations to help ensure the safety of patients.

The practice used a range of information to identify risks and to improve patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed incident reports and minutes of meetings where incidents were discussed from the last 18 months. This showed the practice had managed incidents consistently over time, and so could evidence a safe track record.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, staff had identified a medicines fridge failure resulting in unstable vaccines. This was reported and the vaccines were destroyed and replaced.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. We saw that a system was in place for reporting, recording and monitoring incidents, accidents and significant events. Records were kept of incidents and events that had occurred during the last 10 years.

We looked at four recent significant events. These were completed in a comprehensive and timely way, and included action taken. For example, it was identified that a medical condition entered on a patient's record was incorrect. This was reported, investigated and followed up with the relevant health workers to address the error and prevent further incidents.

Records of significant events showed that appropriate learning and improvements had taken place, and that the findings were communicated widely. We noted that two separate events relating to delayed diagnosis did not include a wider review, to compare any factors or adverse effect on the outcome for other patients with similar conditions. The GPs partners acknowledged the value of completing this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all staff had received safeguarding training specific to their role. For example, all GPs had completed level three training. Clinical and administrative staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies.

There was a system to highlight vulnerable patients on the practice's electronic records system, including children and young people who were looked after, or on a child protection plan. The alert system ensured that they were clearly identified and reviewed, and that staff were aware of any relevant issues when patients attended appointments or contacted the practice.

One of the GPs was appointed as the lead in safeguarding vulnerable adults and children. Staff we spoke to were aware of the GP lead, and who to speak to if they had a safeguarding concern. The lead GP for safeguarding was aware of vulnerable children and adults registered with the practice.

Records showed good liaison with relevant professionals and partner agencies such as children's social care. The lead GP and the health visitor were based at the practice. Whilst the lead GP and health visitor shared information about vulnerable children, they did not meet regularly to discuss safeguarding issues and children on a child protection plan, to ensure they were safe and protected from harm. There were plans to hold regular meetings.

A chaperone policy was in place, which was visible in the waiting area and consulting rooms. Discussions with staff and records showed that staff who acted as chaperones had undertaken relevant training. Staff understood their

responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Clinical staff were also due to attend chaperone training by 31 October 2014.

Patients' individual records were managed in a way to keep people safe. Records were kept on EMIS electronic system, which held all information about the patient including scanned copies of results and communications from hospitals. The practice had completed a risk assessment in regards to the storage of written medical records to ensure that these were kept secure.

Medicines Management

Several patients and representatives told us that the system in place for obtaining repeat prescriptions generally worked well to enable them to obtain further supplies of medicines.

Arrangements were in place to enable patients to collect their dispensed prescriptions directly from a community pharmacy. The practice had plans in place to introduce electronic prescribing to further improve medication safety, prescribing, efficiency and access to medicines. This will mean that patients will be able to choose a place for their GP practice to electronically send their prescription to, saving them time and enabling them more choice as to where they could get their medicines from.

We found that medicines were stored appropriately and securely. Policies and processes were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance, to ensure they were kept secure.

A system was in place relating to the management of high risk medicines, which included regular monitoring in line with national guidance. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures in place that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook an annual audit of controlled drug prescribing to ensure that the medicines were managed appropriately. Staff were aware of how to raise concerns around controlled drugs with the accountable officer in their area.

Cleanliness & Infection Control

We observed the premises were visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept, to ensure that the practice was hygienic. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness.

One of the GPs was appointed as the lead for infection control. Staff we spoke with said that they had received training on infection control and hand washing, specific to their role. They also had access to the policy and procedures to enable them to apply infection control measures. For example, personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use to comply with the practice's infection control policy.

The infection control policy stated that an annual audit of procedures was carried out. We saw that an infection control audit was completed on 26 September 2014. The report included action taken to rectify shortfalls that had been highlighted. The practice manager assured us that an audit was completed every six months, and that the findings and any remedial actions were shared with the staff team.

We checked various stock supplies of clinical and medical items; all items were in date. Records showed that relevant staff checked the supplies at regular intervals to ensure they remained in date, were sealed where required, and were used appropriately.

The practice had a policy for the management and testing of legionella (bacteria found in the environment which can

contaminate water systems in buildings). Records showed that the practice was carrying out regular checks in line with their policy to reduce the risk of infection to staff and patients.

A policy was in place relating to the immunisation of staff at risk of the exposure to Hepatitis B infection, which could be acquired through their work. The records showed that relevant staff were protected from Hepatitis B infection.

Equipment

Staff we spoke with confirmed that all equipment was safe to use, and that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Maintenance logs and other records showed that all equipment was regularly tested and maintained, including items requiring calibration such as weighing scales and blood pressure machines. A schedule of testing of all equipment was in place.

Staffing & Recruitment

Discussions with staff and records we looked at showed that robust recruitment procedures were followed by the practice, to ensure that staff had the relevant skills and experience and were suitable to carry out the work. A system was in place to ensure that the nurses and GPs were registered to practice with the relevant professional body prior to employment, and continued to remain registered and fit to practice. The practice manager agreed to review the recruitment policy, to ensure it detailed all stages of the process and information obtained when recruiting clinical and non-clinical staff.

We checked the files of two staff employed in the last 12 months. These showed that appropriate recruitment checks had been undertaken prior to employment, except for proof of identity including a recent photograph. Following the inspection, the practice manager provided written assurances that all staff files had been updated to include proof of identity including a recent photograph.

Staff told us about the arrangements for ensuring sufficient numbers and skill mix of staff was available to meet patients' needs. Members of staff covered each other's annual leave and absence. Staff considered that there was usually enough staff on duty to ensure patients were kept safe, and to maintain the smooth running of the practice. However, following a reduction in funding the practice did not plan to replace two part time nurses who were due to leave shortly. Senior managers assured us that the reduction in staffing levels and skill mix would be reviewed to ensure the smooth running of the practice.

Monitoring Safety and Responding to Risk

The practice had systems and policies in place to identify, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment and medicines management. Action plans were put in place to reduce and manage any risks. These were discussed at GP partners' and team meetings. The practice had a health and safety policy, which staff had access to. The practice manager was the health and safety representative.

We saw that staff responded to risks to patients including deteriorating health and well-being or medical emergencies. For example:

Emergency processes were in place for patients with long term conditions. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

There were emergency processes in place for identifying acutely ill children and young people.

Emergency processes were in place for acute pregnancy complications.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The training matrix showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that the emergency equipment and medicines were regularly checked to ensure they were fit to use and within their expiry date. All the medicines we checked were in date and suitable to use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the day to day running of the practice. Risks identified included power failure, adverse weather, staff changes and access to the building. Actions were recorded to reduce and manage the risks.

A fire risk assessment had been completed, which included actions required to maintain fire safety. Records showed that all staff were up to date with fire training and that fire drills were carried out every six months, to ensure that people knew how to evacuate the premises, and what to do in the event of a fire.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with said that they received updates relating to current best practice and the National Institute for Health and Care Excellence (NICE) guidelines electronically. The aim of these guidelines is to improve health outcomes for patients. Staff also told us that they discussed clinical issues and changes to practice at weekly meetings. The minutes of meetings we looked at confirmed this. The GPs had taken on lead roles in clinical areas such as diabetes, heart disease, asthma and palliative care. The practice nurses supported this work which enabled the clinicians to focus on specific conditions and to drive improvements.

The practice knew the needs of their patient population well. There was a holistic and pro-active approach to meeting patients' needs which was driven by all staff at the practice. We found from discussions with the clinical staff that they completed thorough assessments of patients' needs.

Systems were in place to ensure that older people, those in vulnerable circumstances, with long term conditions and experiencing poor mental health received an annual health review, including a review of their medicines. A system was in place to recall patients for an annual review. Regular multi-disciplinary meetings were held to review the health needs and care plans of patients who had complex needs and were receiving end of life care. The practice referred patients appropriately to secondary and other community care services. Patients were referred on the basis of need.

Patients over 75 years had a named GP to ensure continuity of care and oversee that their needs were being met. The practice part funded a community matron post to support elderly patients and people with complex needs who lived in their own homes and local care homes, to prevent avoidable admissions to hospital and improve outcomes for patients.

The community matron regularly visited above patients in their own home and local care homes in response to their needs, and reviewed and referred them to ensure their needs were being met. They also helped the staff to complete appropriate assessments and care plans for patients, and provided advice and support to develop staff's knowledge and skills. Representatives from three care homes we spoke with praised the support staff and patients received, and felt that the community matron's input was invaluable in improving the care and outcomes for patients.

Records showed that the community matron and practice manager held quarterly meetings with the care home managers to review developments relating to patients' needs. We saw where the community matron's input had improved the outcomes for patients. For example, the out-of–hours service had previously been called regularly in regards to one patient. However, following her involvement, the patient was referred to an appropriate service and their health had improved.

Patients with a learning disability were offered an annual health check, including a review of their medicines. At the end of the review the patient was provided with a health action plan in an easy read format to meet their needs. Staff were updating the health review form to include further information. Clinical staff worked closely with the local learning disability team to ensure all patients with a learning difficulty received appropriate care and treatment.

Staff also worked closely with the local mental health team to ensure that patients experiencing poor mental health were regularly reviewed, and that appropriate risk assessments and care plans were in place.

There was evidence of a strong patient centred culture. For example, the practice provided medical support to a local drug misuse service, and was helping to change perceptions about people who had a drug dependency**.** The lead GP for drug misuse told us how the practice worked closely with relevant services, which had enhanced their safeguarding links and holistic approach to supporting families and patients who had a drug dependency. The substance misuse service is a positive example of how the practice was pro-active in working with a hard to reach vulnerable group despite the challenges.

The practice provided ante natal and post natal checks, with involvement of the community midwife. There were systems in place that ensured babies received a new born and six week development assessment in line with the Healthy Child Programme.

Management, monitoring and improving outcomes for people

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The services were very effective as all staff had clear roles in monitoring and improving outcomes for patients resulting in a practice wide approach to care and treatment. 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 national performance measurement tool. Records showed that the practice achieved total of 99.8% in the QOF performance for 2012 to 2013. This was above the average for practices in England and locally.

The team made use of audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. We saw that a system was in place for completing clinical audit cycles to provide assurances as to the quality of care, and to improve the outcomes for patients.

Various audits and reviews had been completed in the last two years, and the practice was able to demonstrate the changes resulting from these. For example, a review of prescribing processes was completed in May 2014, resulting in various changes to how prescription requests were processed, to ensure they remained appropriate and were managed safely.

Staff told us that the outcome of audits was communicated through the team and clinical meetings. Records showed that weekly clinical meetings were held involving the GPs and nurse practitioner. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

Effective staffing

We found that the practice had an established staff team with extensive knowledge, skills and experience to enable them to carry out their roles effectively. This ensured continuity of care and services. The training matrix showed that all staff were up to date, and had attended mandatory courses such as safeguarding and annual basic life support. The practice closed for half a day on a Tuesday each month to enable all staff to receive time for learning. Further training needs had been identified and planned.

Staff told us they worked well together as a team. They also said that they were supported to share best practice, acquire new skills and further develop their competence and knowledge to meet patients' needs and provide high quality care. For example, the healthcare assistant had received relevant training to undertake certain cardio vascular and pulmonary checks. The member of staff assured us that they had been assessed competent to carry out the tasks, although a competency assessment was not available to support this view.

Staff assured us that they had received appropriate induction training to enable them to carry out their work. The practice manager told us that all new staff completed a generic induction form. We saw that the induction form was not relevant to specific roles to ensure that staff received essential information to carry out their work. The practice manager agreed to review this. Staff told us that they received annual appraisals which identified their learning needs from which action plans were recorded. Staff files we looked at confirmed this.

Records showed that staff received supervision through peer support and regular team meetings they attended. They also received an annual appraisal to review their performance and learning and development needs. We looked at three completed appraisals. The records showed that a robust appraisal system was in place, which reviewed staff's training and development needs and set objectives.

GPs told us that they were up to date with their professional development requirements, and had either been revalidated or had a date for this. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date with current best practice and remain fit to practice. The practice was a training practice. Doctors who were in training to be qualified as GPs received extended appointment times, and had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice had strong links locally and nationally with other service providers to aid communication and multidisciplinary working. For example, the senior partner also worked on the out-of hours service, and provided medical support to the East Midlands Ambulance service and the emergency on call response group.

Staff worked with partner health and social care services to meet patients' needs. Records showed that the practice held regular multidisciplinary team (MDT) meetings to

discuss complex patents, including those with end of life care needs, or in vulnerable circumstances. These meetings were attended by district nurse, social worker, school nurse and palliative care nurse.

The practice had signed up to the enhanced service to avoid unplanned admissions and to follow up patients discharged from hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients. It was clear from discussions with staff that considerable work went into supporting people to remain in their own home, and ensuring they received appropriate support on discharge from hospital. For example, the practice was involved in a local 'falls' initiative, which enabled patients who had fallen at home and had been taken to hospital for assessment, to be promptly returned home on discharge.

The practice also worked closely with the out-of-hours service to ensure that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid unnecessary admissions.

Information Sharing

A shared system was in place with the local out-of-hours provider to enable essential information about patients to be shared in a secure and timely manner. The practice used EMIS electronic system to coordinate record and manage patients' care. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference.

For patients requiring emergency assessment or admission to hospital from the practice, the GPs provided a printed summary record for the patient to take with them. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key information).

Electronic systems were also in place for making referrals. The practice had invested in a digital dictation system, which enabled clinicians to dictate and send referrals easily. The Choose and Book system enabled patients to choose which hospital they wished to be seen in, and to book their own outpatient appointments.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to.

We found that arrangements were in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements. Written consent was obtained for specific interventions such as minor surgical procedures, together with a record of the possible risks and complications.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff understood the importance of determining if a child was Gillick competent especially when providing treatment and contraceptive advice. We saw an example where this had been applied in practice. A Gillick competent child is a child under 16 who is capable of understanding implications of the proposed treatment, including the risks and alternative options.

Staff were able to demonstrate an awareness of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements. However, they had not received formal training to ensure they understand the principles of the act and the safeguards. The practice manager had put plans in place to provide appropriate training for all staff by February 2015.

It was clear from discussions with clinical staff that arrangements were in place for patients receiving end of life care. All patients who were part of the admission avoidance had a 'Right Care' plan to ensure that their wishes were respected, including decisions about resuscitation and end of life care. This information was available to the out -of -hours service, ambulance staff and local hospitals.

Health Promotion & Prevention

We saw that a wide range of health promotion information was available to patients and carers

on the practice's website, and the noticeboards in the surgery. New patients completed a form, which provided some information about their lifestyle and health. It was not policy to offer new patients registering with the practice

Outstanding ☆

Are services effective?

(for example, treatment is effective)

an initial health check, to ensure that staff had access to essential information about people's health needs, and that any tests or reviews they needed were up-to-date. The practice manager agreed to review the policy with the partners.

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 for all immunisations was above average for the area CCG, and there was a system in place for following up patients who did not attend.

The practice had links with local schools and had provided several presentations to pupils about health issues. Pupils from a local school had designed the new logo for the practice.

The practice offered NHS Health Checks to all patients aged 40 to 75 years. Practice data showed that 67% of patients in this age group had taken up the offer of the health check.

The cervical smear uptake was meeting the 80% target rate set by the area CCG. There was a system in place for following-up patients who did not attend screening. The practice also had systems in place to identify patients who needed additional support, and were pro-active in offering help.

All patients with a learning disability, experiencing poor mental health, over 65 years, with long standing conditions or aged 75 years and over were offered an annual health check, including a review of their medication.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Nine patients we spoke with described the staff as friendly, caring and helpful, and felt that they treated them with dignity and respect. They also said that they felt listened to and that their views and wishes were respected, and that confidentiality was maintained. Representatives of three care homes we spoke with where patients were registered with the practice, also said that they felt that the staff team was caring and treated patients with respect. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room.

The 2014 national GP survey showed that 67% of patients surveyed were satisfied with the level of privacy when speaking to receptionists at the practice. This was above the CCG average for the area. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. Staff told us that recent alterations to the layout of the waiting area and the reception desk had improved confidentiality. They also said that if they observed any instances of discriminatory behaviour, or where patients' privacy and dignity was not respected they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

Nine patients we spoke with said that they felt listened to, and were supported to make decisions about their care and treatment. The 2014 national GP survey showed that 85% of people surveyed said that the last GP they last saw or spoke to, was good at involving them in decisions about their care, and 90% felt the GP was good at explaining treatment and results. These results were above the CCG regional average. The practice's 2013 patient survey also showed that patients felt listened to, and involved in decisions.

The practice had signed up to the enhanced service to avoid unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. Clinical staff assured us that all patients assessed at high risk of being admitted to hospital, including certain elderly patients and people with complex needs or in vulnerable circumstances, had a care plan in place to avoid this. The care plans included patient's wishes, decisions about resuscitation and where they wished to receive end of life care.

The above information was available to the out-of -hours service, ambulance staff and local hospitals. The practice used an alert system to ensure that the out -of-hours service were aware of the needs of these patients when the surgery was closed.

Clinical staff we spoke with and records we looked at showed that an annual health review was carried out for patients with a learning disability using a health check template. At the end of the review the patient was provided with a health action plan which was agreed with them. This was provided in an easy read form so that patients understood it.

Patients with mental health difficulties were also offered an annual health review. A plan was recorded in regards to their health needs, which was agreed with them.

Staff told us that some patients attending the practice required support to make decisions about their care and treatment, including people with a learning disability or dementia.

We noted that staff and patients did not have access to information about local advocacy services. Following the inspection, we received assurances that the practice's web site had been updated to include information on advocacy support. The information had also been included on the electronic screen in the waiting area, and the practice leaflet, which was being reprinted. Staff had been made aware of this.

The practice had a 98% white British population. The information on the web site was available in various languages, for patients whose first language was not English. Senior managers assured us that staff and patients attending the practice also had access to a translation service. However, two clinical staff we spoke with were not aware of this. A nurse referred to a patient who had attended the practice who did not speak English. Her husband translated for her. The patient had not been offered the option of using a translation service, as the staff were not aware that this was available. The practice manager agreed to ensure that all staff were aware of the above service.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Patients we received comments from said that they received support and information to cope emotionally with their condition, care or treatment. Where able, they were supported to manage their own care and health needs, and to maintain their independence.

The 2014 national GP survey showed that patients were satisfied with the support provided by the practice. For example, 91% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern, and 94% said that they were good at listening. 84% also said that the last nurse they saw or spoke to was good at treating them with care and concern. These results were above the CCG regional average.

We saw that the computer system identified patients who had carer responsibilities to enable the staff to offer them support. It was apparent from talking with staff that importance was given to supporting carers to care for relatives receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP, to determine whether they needed any practical or emotional support. The practice also sent a letter of condolence to the carer.

The practice was recently awarded a Carers Pledge and was due to complete a bronze dignity award. The Carers Pledge sets out the practice's commitment to ensuring that carers feel valued, have access to appropriate information and are supported and signposted to relevant services, to enable them to continue their caring role. The bronze dignity award recognises positive changes the practice has made to ensure that patients are treated with dignity and respect.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Representatives of three care homes we spoke with said that patients were promptly seen where required and their needs were regularly reviewed. The community matron regularly visited patients and was pro-active in responding to their needs, and preventing health issues from becoming more serious.

We found the practice provided a wide range of services to meet patients' needs, and enable them to be treated locally. For example, the practice employed a phlebotomist to enable patients to have their blood tests done at the practice. Patients care and treatment was coordinated with other services and providers. The services were flexible, and were planned and delivered in a way that met the needs of the local population.

Antenatal care and support to younger children was provided by the designated midwife and health visitor, who held weekly clinics at the practice. The health visitor was also based at the surgery, which enabled the GPs and staff to discuss any issues face to face.

A mental health worker also held regular clinics at the practice to support patients experiencing poor mental health. Counselling services were also available. Regular multidisciplinary meetings were held to discuss patients with complex and high risk needs, including persons receiving end of life care. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

The practice had an established staff team, providing continuity of care and access to appointments. We saw that systems were in place to ensure that test results, information from the out-of-hours provider and letters from the local hospital including discharge summaries were promptly seen, correctly coded and followed up by a GP, where required.

Responsive systems were also in place to ensure that patients were promptly referred to other services, where required. GPs told us that the investment in the digital dictation system had meant that referrals could be sent quickly.

The practice worked in partnership with the Patient Reference Group (PRG) and responded to information to meet patients' needs. The PRG includes patient representatives who work with the practice to improve the quality of care and services. In response to concerns about access, the phone system had been upgraded, and the appointment system had been changed to meet patient demand. The practice website had also been redeveloped with involvement of patients to ensure the information met their needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services, and worked in partnership with other providers and services to understand the diverse needs of patients. Staff informed us they operated an open list culture, accepting patients who lived within their practice boundary.

The lead GP for drug misuse told us how the practice worked closely with relevant services to support families and patients who had a drug dependency. The practice provided medical support to the local drug misuse service, and was helping to change perceptions about people who had a drug dependency.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

Access to the service

Patients told us they were able to get an appointment or were offered a telephone consultation, where needed. However, a few patients reported difficulty in getting through to the practice by phone, and obtaining an urgent appointment at times.

The 2014 national GP survey showed that 86% of people surveyed, were able to get an appointment to see or speak to a clinician the last time they tried. However, 42% said that they had not found it easy to get through to the practice by phone. Records showed that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs. In response to recent concerns about access, the practice had made appointments bookable two weeks in advance. Previously they were bookable a week in advance.

Patients had access to information about the appointment system, opening times and the out-of-hour's service on the practice's website. The information was also available in

Good

Are services responsive to people's needs?

(for example, to feedback?)

the reception area. The practice website provided a wide range of information about various services, and included a translation facility for people whose first language was not English to enable them to access the information.

Patients were able to book an appointment in person, by telephone, on line or by using the automated booking service. Extended opening hours were available from 7.30 am until 8 pm on Tuesday and until 8 pm on Monday. This enabled children and young people to attend appointments after school hours. It also enabled working age patients and those unable to attend during the day, to attend in an evening or early morning. We saw that systems were in place to prioritise emergency and home visit appointments. Telephone consultations were available for patients who were not well enough to attend the practice.

Records showed that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs. For example, in response to recent concerns about access, the practice had made appointments bookable two weeks in advance. Previously they were bookable a week in advance.

We found that the facilities and the premises were accessible and appropriate for the services being delivered. Considerable investment had gone into upgrading the facilities, and improving access to the premises to ensure it met the requirements of the Disability Discrimination Act. The majority of patient facilities were on the ground floor.

Patients with health or mobility difficulties were seen on the ground floor. Having assessed the need, cost and work involved, a lift had not been installed to the first floor as access was not an issue.

Listening and learning from concerns and complaints

Patients we spoke with said that they felt listened to and able to raise concerns about the practice. They were aware of the process to follow should they wish to make a complaint, but they had not had cause to do so. We saw that the practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for handling complaints in the practice, with involvement of the GP partners.

We looked at the records of complaints received in the last 12 months, which showed that concerns had been acknowledged, investigated and responded to in line with the practice's policy. Complaints received were reviewed to identify any patterns, and to ensure they had been responded to in a timely way.

Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that complaints were shared with the team, and acted on to improve the service for patients. Records supported this. For example, as a result of complaints staff had received further training on customer service. The practice had received no further concerns.

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

There was a clear vision and strategy to deliver high quality care and promote good outcomes for patients, which was shared by the staff team. A clear business plan was in place, which set out the plans for future development and demonstrated a commitment to ongoing improvement. The plans included completing a friends and family survey, establishing electronic prescribing; making nurses appointments bookable on line and completing further building and refurbishment work.

Improvements over the last 12 months included developing the web site to ensure it met patients' needs, refurbishment of the reception area to improve access and confidentiality, upgrading the phone system and introduction of a patient calling system to improve information.

There was a clear understanding of the challenges facing the practice and the locality in general, and they were keen to play their part in leading on greater development.

Governance Arrangements

We found that effective systems were in place for gathering, recording and reviewing information about the safety and quality of services that people received. Robust systems were also in place for identifying, recording and managing risks. The practice had undergone considerable changes in the last 18 months. The systems to drive improvement and monitor the quality of care and services had been strengthened.

Comprehensive policies and procedures were in place to support the effective running of the practice, which had been reviewed in the last 12 months to ensure they were up-to-date. A schedule was set out for 2015 to 2017 to highlight when these were due to be reviewed. Staff had access to the policies; a system was in place to show that staff had been made aware of these.

There were robust systems in place to ensure the effective governance of the practice. The minutes of meetings showed that the GP partners held weekly meetings to discuss the business, including finances, governance and performance. Monthly clinical meeting were also held to discuss clinical issues and to share best practice.

Records showed that various clinical audits were carried out. Completed clinical audits were used to monitor, measure and improve the quality of care and outcomes for patients. These showed that essential changes had been made to ensure that patients received safe care and effective treatment.

The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOFdata showed that the practice was performing in line with, or above national and local standards in all listed clinical areas. The QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a clear leadership structure which set out staff's lead roles and responsibilities to ensure that the service was consistently well managed. For example, the community matron was the lead for avoidance admissions, care homes and chairing multi-disciplinary team (MDT) meetings and one of the GP partners was the lead for safeguarding, substance misuse and prescribing.

All staff we spoke with were clear about their own roles and responsibilities, and felt that the practice was well led. The practice manager and GP partners showed that they had the necessary experience, knowledge and skills to lead the team effectively.

The staff team worked together to enable one of the GP partner's to take time out of the practice to undertake a senior national role in emergency care and medical contracts and negotiations. The partner's national role helped to inform the staff team of current policy and developments. For example, the team were informed of proposed changes to the immunisation programme in advance of other practices, which enabled them to plan and deliver their immunisation programme more effectively.

The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet patients' needs, and to drive continuous improvements. This was illustrated by the prominent role of the community matron, and the significant improvements the practice manager had made over the last year to ensure that robust processes and systems were in place.

Are services well-led?

Outstanding ☆

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

There was strong teamwork, leadership, and commitment to improving the quality of care and people's experiences amongst all members of practice staff. There was a very open, positive and supportive culture. This was evidence by the response to incidents, significant events and complaints.

Staff we spoke with all told us they felt able to raise any issues with senior managers as they were approachable. The practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it.

Records showed that regular team meetings and away days were held, which enabled staff to share information and to raise any issues. Staff said that they felt involved in decisions about the practice, and were asked for their views about the service. They also said that they enjoyed their work and felt valued and well supported There were high levels of staff satisfaction and engagement.

Practice seeks and acts on feedback from users, public and staff

The practice obtained feedback from patients through the national GP patient survey and complaints. The practice had a Patient Reference Group (PRG), which includes representatives from various population groups, who work with staff to improve the quality of care and services for patients.

We spoke with two members of the PRG. They told us that the group had tried to enlist a member to represent younger people; however no one had expressed an interest. They also said that the practice valued their role, and asked for their views to improve the service. For example, when the reception area was being refurbished they were consulted about purchasing chairs, automatic doors, noticeboards, and floor coverings. They were also involved in recruiting the current practice manager.

The PRG carried out an annual patient survey. The results and actions agreed from recent surveys were available on the practice web site and at the practice. These provided assurances that patients were asked for their views, and their feedback was acted on to improve the service.

There was an active approach to seeking out new ways of providing care and treatment. Discussions with staff and records showed that the practice obtained feedback from staff through away days, team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the service to improve outcomes for patients and staff.

Management lead through learning & improvement

Staff said that they were supported to maintain and develop their skills and knowledge. Records showed that staff received ongoing training and development and an annual appraisal to enable them to carry out their work effectively.

Records showed that accidents, incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences.

Minutes of practice meeting showed that appropriate learning and improvements had taken place, and that the findings were communicated widely.