Egton Surgery

Inspection report

Egton
Whitby
North Yorkshire
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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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall.

(Egton Surgery is a new registered single handed practice and this is the first inspection of this service under this provider.)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Egton Surgery on 25 April 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured care and treatment was delivered according to evidence-based guidelines.
- Clinicians had access to appropriate information to deliver safe care and treatment.
- Patients said they were treated with compassion dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients to understand the care available to them.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported they were able to access care when they needed it. Patient feedback on the care and treatment delivered by all staff was overwhelmingly positive.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding practice:

- We were provided with many examples of feedback from patients to say how they valued the care delivered by all members of staff and the support they provided. The staff provided lifts to take patients to appointments and the nurse worked during her lunch time to accommodate patients struggling with transport issues.
- The practice, in collaboration with a neighbouring practice developed processes to share some management responsibilities, improve learning and share best practice. These arrangements included the development of a practice nursing team with specific skills that can be used across the practices.
- Patients and their families at the end of life were given the GPs personal mobile phone to contact 24hours seven days of week to contact them if they were needed.
- Patients were also able to access the skills of GPs with specialist skills at this practice or one of the nearby practices There is formal agreement with the neighbouring practices to access these skills. This reduced the need to refer patients to secondary care which means a considerable journey for some patients.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a medicines specialist advisor.

Background to Egton Surgery

Egton Surgery is situated at Egton, Whitby situated in the national park six miles from Whitby. They are a member practice of the Hambleton, Richmondshire and Whitby, Clinical Commissioning Group (CCG). Egton Surgery provides services under a general medical services (GMS) contract with NHS England to approximately 2366 patients.

The surgery is housed in a two-storey purpose-built accommodation with all patient services on the ground floor offering access and facilities for wheelchair users. The practice website can be found at http: www.egtonsurgery.nhs.uk.

The practice population includes a higher number of patients aged 65 plus which was 40% this was above the 27% nationally.

Information published by Public Health England, rates the level of deprivation within the practice population group as six on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Male and female life expectancy in the practice geographical

area is higher the national average at 80 years for males, compared to 79 years nationally and 84 years for females, compared to 83 years nationally.

The practice is able to offer dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. Practice opening hours are from 8am to 6.30pm Monday, Tuesday, Thursday and Friday and on Wednesday the practice is open 8am to12 pm. Extended hours appointments are offered on Tuesday between 7am and 8 am and on a Saturday morning between 8.30am and 12 pm (these appointments are held at the Better Access clinic at Churchfield Surgery (Sleights). Appointments with GPs at the practice are from 8.30am -12.00pm and 3.30pm to 6pm, the exception is on a Wednesday which is between 8.30am and 11am. When the practice is closed, patients are able to access out of hour's services by telephoning NHS 111. On a Wednesday after 12pm calls were transferred to Danby Practice they responded to any patient requests they were also able to book appointments for patients.

There are two GPs, one male GP partner and one female salaried GP, one practice nurse, one community practice nurse, three health care assistants and staff who dispense prescriptions including a dispensary supervisor. These are supported by a practice manager, office manager and an experienced team of reception/administration staff. The practice uses when possible locums well known to them. For example the recently retired ex- partner. There is a practice policy in place to ensure that the two GPs are

never away from the practice at the same time. This provides continuity of care for patients. The practice is a training practice for both medical students and GP trainees. They also host nurses undertaking training.

The practice provides family planning, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure facilities and equipment were safe and in good working order. Staff carried out actions to manage risks associated with legionella in the premises (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. Staff met weekly to ensure there were sufficient patient appointments available in the coming week. Arrangements were made to provide additional appointments with clinical staff when necessary.
- There was an effective induction system for permanent and temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. All staff were trained in first aid.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff had access to policies in relation to patient medical emergencies. Clinicians knew how to identify and manage patients with severe infections including sepsis. The practice had arranged training for the reception staff in recognising the signs of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. We saw a range of risk assessments completed by the practice.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed information needed to deliver safe care and treatment was available to staff.
- Care plans for vulnerable patients were completed in the patient's home with the community matron and the patient.
- There was a documented approach to managing test results. Test results were dealt with in a timely way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. We saw evidence the practice had reduced antibiotic prescribing in the last 12 months and was within the national average.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The practice reviewed prescribing and provided an additional safety net for patients taking high-risk medicines.
- The practice had input from a pharmacist provided by the CCG who reviewed all hospital discharges against the practice records to check and action any required changes to medication.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to most safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. We saw evidence that the practice had taken action as a result of incidents that had benefited other local practices and led to safer services.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. Although this data is related to the previous provider, systems and staffing have remained largely the same.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- All clinical staff had easy and immediate access to both written and online best practice guidance.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. Frail patients have a red folder in their home with their care plan and are regularly assessed.
- The practice offered a health check to patients aged over 75 where indicated. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs. The practice was able to use the community practice nurse to assess and support vulnerable patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice, as a dispensing practice was able to dispense and deliver medication to the housebound.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. The nurse was able to offer the DESMOND course in the practice for patients diagnosed with type two diabetes. DESMOND is the acronym for Diabetes Education and Self-Management for Ongoing and Newly Diagnosed patients.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma and other long term conditions.
- The practice had arrangements to work closely with specialist nurses such as diabetes, heart failure, respiratory, tissue viability and continence to provide the best care for patients.
- The practice focussed on education and self-management plans with patients.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were higher than the target percentage of 90% ranging between 90% and 100%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisations.
- The practice held monthly combined clinics with the health visitor and practice nurse.

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

Good

Are services effective?

- The practice's uptake for cervical screening was higher than the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was higher than the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease and cancer. The practice provided 'stop smoking' and weight management in-house. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practice reviewed the care of patients diagnosed with dementia in a face to face meeting every year.
- Patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their medical records and reviewed each year.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- The practice also promote 'silvercloud' which is Cognitive Behavioral Therapy (CBT) available online and classes on stress control.,
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice also signposted to local dementia support groups.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice used information about care and treatment to make improvements. Staff had audited practice prescribing of antibiotics against best practice guidelines. Where appropriate, clinicians took part in local and national improvement initiatives. The practice had entered into a quality contract with the clinical commissioning group (CCG) to improve the pathway of care for diabetes. This included the training of staff to deliver services closer to the patient's own home.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice used these to monitor and ensure the competence of staff.

Good

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

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

- We saw records that showed all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents and the housebound. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors, school nurses and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The GP provided families and patients with their mobile phone number when the patient was approaching end of life.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes (Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services for example sport or volunteering) . The practice offered blood pressure monitors to patients with high blood pressure so they could record levels at home.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as Outstanding for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was overwhelmingly positive about the way staff treated people. We saw and heard many patient comments which related to outstanding staff behaviour and staff going out of their way to help patients. For example taking patients to their hospital appointment when the transport for a patient failed to arrive on many occasions. The nurse changed her work day to accommodate patients struggling to get into the practice for appointments. The practice is situated in a rural area with people often living in remote areas and with poor transport links. In this small rural community patients and their families were well known to the practice staff and often provided the staff with knowledge of patients problems both clinically and socially.
- Staff understood patients' personal, cultural, social and religious needs. The practice had appointed a "carers champion" to lead on issues affecting carers and signposting them to the help and support they needed. The champion received training provided by health and social care to help them identify and support young carers.
- The local community met regularly for coffee mornings and dementia lunches in the hall near the surgery. The practice staff and PPG regularly attended these events or dropped in to purchase refreshments providing the opportunity for people to meet, socialise and receive information.
- The PPG supported the Practice's prescription delivery service providing car drivers to deliver the prescriptions to patients who were unable to collect these. The service was provided to patients who were housebound ensuring patients receive their medication as often they lived long travelling distances from the practice. The contact also provided a visit to patients often facing social isolation. This initiative was achieved after a successful set up bid to Rural Action Yorkshire. The service was fully risk assessed and a governance process was in place.
- The surgery offered open access for the flu vaccination in the practice for patients attending the Egton Village Coffee Mornings during the flu season.
- Because the practice was small and staff turnover was low, staff had developed good knowledge of patient personal circumstances. We were provided with many examples of where patients had been treated in an understanding and compassionate way. For example, when bereavements or accidents occurred in the local community, the practice immediately recognised when further support was necessary and arranged for this without delay. We saw many examples of a strong, visible person-centred culture.
- Patients who were anxious when waiting in the busy practice waiting room were given the option to wait in a separate room, with staff support if necessary, or to wait in their car until a member of staff told them that it was time for their appointment.
- The practice gave patients timely support and information.
- The practice was consistently higher in the GP national survey than other practices in the clinical commissioning group (CCG) and national averages for questions related to kindness, trust, respect and compassion.
- Patients and their families at the end of life were given the GP's mobile phone number making themselves available to be contacted if needed. This service is provided 24 hours a day and at weekend to ensure continuity of care delivered at a most difficult time for patients and their families. The service is unfunded but provided by the practice as part of their commitment to delivering continuity of care.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given) and staff had trained in this standard.

- Staff communicated with people in a way they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Outstanding ☆

Are services caring?

- The practice was consistently higher in the GP national survey than other practices in the CCG and national averages for questions related to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice and all of the population groups as good for providing responsive services. Responding to and meeting people's needs The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Patients could email the practice with any queries.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a delivery service, weekly or monthly blister packs and large print labels.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Patients aged over 75 were offered longer appointments with a GP as required.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs and practice community nurse also accommodated home visits for those who had difficulties getting to the practice.
- There was a medicines delivery service for housebound patients provided by the PPG.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. The practice had reviewed the way that these reviews were carried out and enabled multiple conditions to be reviewed at one appointment. Consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local integrated teams to discuss and manage the needs of patients with complex medical issues.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours which originally had been funded by monies obtained through the Prime Ministers challenge fund. The work has continues to provide good access for patients and joint working across the practices to improve patient care.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours. The practice also trailed and now offered
- The practice offered NHS health checks to patients aged between 40 and 74 years of age.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice proactively identified those patients who were showing signs of dementia and referred them to secondary care when appropriate.

Good

Are services responsive to people's needs?

Older people: People with long-term conditions: Families, children and young people: Working age people (including those recently retired and students): e- consultations. People whose circumstances make them vulnerable: People experiencing poor mental health (including people with dementia): **Timely access to care and treatment** Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Staff met with GPs weekly to ensure that there were enough appointments available in the near future. GPs supplied extra appointments or employed a locum GP when necessary.
- The practice was significantly higher in the GP national survey than other practices in the clinical commissioning group (CCG) and national averages for questions related to access to the practice.

Listening and learning from concerns and complaints The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. All patient complaints were discussed with staff so that they could reflect on their practice. We saw that the three complaints that the practice had received allowed for this reflection and did not give rise to any learning needs. In all cases, patients were reassured that their treatment had been appropriate and further advice had been given.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice were meeting to review their business plans since becoming a single handed GP practice. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. This was being done jointly with other local practices in order to map out services and provide them in a co-ordinated, streamlined way.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Good

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were sound arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.