Silverdale Family Practice

Inspection report

South Hetton Health Centre
Front Street, South Hetton
Durham
County Durham
DH6 2TH
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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	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as Outstanding overall. (Previous inspection August 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Silverdale Family Practice on 15 November 2018 as part of our inspection programme.

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 consistently reviewed the effectiveness and appropriateness of the care it provided. It ensured care and treatment was delivered according to evidence based guidelines.
- Feedback from patients who used the service, those close to them and external stakeholders was continually positive about the way staff cared for patients.
- Patients found the appointment system easy to use and reported access to appointments was good, staff confirmed this.
- Leaders had the capacity and skills to deliver high-quality, sustainable care. They had an inspiring shared purpose, strived to deliver and motivated staff to succeed.
- Staff told us they felt supported and engaged with managers and there was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

- The practice participated in the Healthier and Wealthier scheme where free benefits and welfare advice was given to patients. The clinicians identified patients in need of advice and arranged a call-back with a trained adviser. As a result of this patients with a 'financial outcome' were on average £3,713 better off. Twenty patient's 'Warwick-Edinburgh' score (a tool used to assess patients' mental wellbeing) improved from an average of 2.38 to 3.25 (out of 5) after they had received the advice.

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

Population group ratings

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

Our inspection team

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

Background to Silverdale Family Practice

Silverdale Family Practice is registered with the Care Quality Commission to provide primary care services. The practice provides services to around 5,728 patients from;

- South Hetton Health Centre, Front St, South Hetton, Co. Durham DH6 2TH.

South Hetton Health Centre is in purpose built premises; all patient services are on the ground floor. There is a car park behind the practice, dedicated disabled parking bays and step free access.

The practice has three GP partners; two male and one female whole time equivalent (WTE) 2.3. There are two salaried GPs WTE 1. There is an nurse practitioner (WTE 1), a practice nurse (WTE 0.6), and one healthcare assistant (WTE 0.9). There is a business manager (WTE 1). There are seven (WTE 6.3) staff who undertake administration duties.

The practice teaches medical students (from first to fifth year) and GP registrars.

The practice provides late evening, weekend and bank holiday appointments;

they are part of the local GP federation of GP practices who work together to provide appointments with GPs, nurses or health care assistants outside of their normal working hours. Patients can contact the practice reception team to arrange appointments. When this service is not provided patients requiring urgent medical care can contact the out of hours provided by the NHS 111 service.

The practice is part of NHS Durham Dales Easington and Sedgefield clinical commissioning group (CCG). The practice provides services based on a General Medical Services (GMS) contract agreement for general practice.

Information from Public Health England places the area in which the practice is located in the third most deprived decile. In general, people living in more deprived areas tend to have greater need for health services. Average male life expectancy at the practice is 79 years, which is the same as the national average. Average female life expectancy at the practice is 81 years, which is lower than the national average of 83 years.

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 Disclosure and Barring Service (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 were systems in place to manage infection prevention and control.
- The practice had arrangements to ensure facilities and equipment were safe and in good working order.
- 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.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- 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.
- At our previous inspection in 2015 we saw the practice was an outlier for antibiotic prescribing. They had acted on this and their data for antimicrobial stewardship showed they were the eighth lowest in the local area out of 39 practices.
- The practice received a letter of thanks from the clinical commissioning group (CCG) in July 2018 for the amount of work they had carried out in delivering savings and quality in the medicines optimisation programme. (Medicines optimisation looks at the value which medicines deliver, making sure they are clinically-effective and cost-effective. It ensures people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team).
- 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.

Track record on safety

The practice had had a good track record on safety.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped them 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.
- 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.

Effective needs assessment, care and treatment

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

- 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 clinicians made decisions about patients' care and treatment.
- 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 have been 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.
- The practice followed up on older patients discharged from hospital. They ensured their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Long term conditions were managed by the clinical team and patients were reviewed at least every twelve months, or sooner. For example, patients with diabetes were reviewed every three to six months.
- The practice provided us with a plan of how they reviewed and managed patients with each type of long term condition.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% or above.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- There was close working with the health visitor and midwife who were based at the practice.
- The practice had equipment to monitor children with breathing difficulties for example, bronchiolitis.

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

- Published data showed the practice's uptake for cervical screening was 74%, which was below the 80% coverage target for the national screening programme. However, the practice provided us with more recent data which showed this was now 78%. The practice had carried out some work on how to increase attendance from patients for these appointments.
- The practice's uptake for breast and bowel cancer screening was in line with 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.
- The practice offered annual health checks to patients with a learning disability.

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, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- However, the quality and outcomes framework (QOF) exception rate was high at 20% (4 patients) for patients experiencing poor mental health who did not have an agreed care plan. The practice had a clear understanding of the rationale for the four exemptions.
- 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.
- 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.

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. Where appropriate, clinicians took part in local and national improvement initiatives.

- The most recent published QOF results showed the practice's overall achievement was 96.5% which was above the national average (96%) but below the CCG average (98.5%). The clinical exception reporting rate was 7.4% compared with a national average of 9.7%.
- The practice used information about care and treatment to make improvements.
- The practice had carried out two cycle clinical audits to improve patient care. For example, The practice carried out an audit to ensure UTI prophylaxis was treated appropriately and in line with local guidelines. At the first audit three patients were identified and an action plan implemented. At the second audit five patients were identified and again an action plan implemented to ensure appropriate care. There were audits of antibiotic prescribing, high dose opioids and the use of psychotropic medication in patients with learning disabilities.
- The practice had the same set of GP partners for four years. There was strong continuity of care for patients.

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 ensured the competence of staff employed in advanced roles by audit of their clinical decision-making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams 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. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have 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.

Good

Are services effective?

- There was good continuity of care. The GPs had worked at the practice together as a team for some time and knew the patients well.
- One of the GPs at the practice had worked with other practices in the locality to help them reduce their antibiotic prescribing.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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. The practice had a higher than average proportion of patients who were obese, with an obesity score at 19.1% compared to the England average of 9.6%. Over the last five years they had referred 91 patients to bariatric consultants, 28 had a marker showing they had received bariatric surgery. The practice ensured patients were advised appropriately for the correct management of their condition.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example, through social prescribing schemes.
- The practice was the pilot site in the local area for Familial Hypercholesterolaemia
  Screening which identified and managed a specific type of high cholesterol that runs in the family, in children, young people and adults. It aimed to help identify people at increased risk of coronary heart disease.
- The practice overachieved on their original target for NHS health checks for 2017/18 (144%).
- 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, tackling obesity. The practice had received an award for outstanding performance for their stop smoking campaign. They offered clinics provided by their practice advisors.

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.

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

Feedback from patients who used the service, those close to them and external stakeholders was continually positive about the way staff cared for patients.

- Eighteen of the 22 Care Quality Commission comment cards, were wholly positive. Patients praised the practice for providing an excellent service. Words used to describe the practice were compassionate, care to the highest possible standard and proud to be with the surgery. Doctors were named individually as going the extra mile and giving exceptional care. Patients said that receptionists went out of their way to be helpful. The four with mixed reviews praised the service and gave some minor criticism to which there were no themes.
- The practice scored higher than the local clinical commissioning group (CCG) and national averages in every question in the National GP Patient Survey for kindness, respect and compassion. For example, respondents to the survey who said the healthcare professional they saw or spoke to was good at treating them with care and concern during their last appointment was 96% compared to the CCG average of 88% and the national average of 87%.
- There was continuity in positive performance from the National GP Survey, for example in 2016 the practice were ranked 46 out of 7612 and in 2018, 347 out of 7109 surgeries.
- The practice had undertaken their own surveys in order to monitor quality, patient satisfaction and access, which showed positive progress.
- There were examples of where the practice had received positive feedback from patients, including numerous thank you letters and cards from patients. The correspondence thanked the practice for their help during hard times, support for palliative patients and for being a credit to the NHS.
- There were positive reviews on both the NHS choices and I want great care website.
- There was positive feedback from other organisations, the local school sent a letter of thanks for the help the practice gave them to raise funds for a defibrillator.
- The Healthwatch enter and view survey was wholly positive.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

There was a strong visible person centred culture. Staff consistently empowered people to have a voice and demonstrate they understand the importance of involving people in their care. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that 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.
- The practice scored higher than the local CCG and national average in the question in the National GP Patient Survey for involvement in decisions about care and treatment. For example, respondents who said during their appointment they were involved as much as they wanted to be in decisions about their care and treatment was 100% compared to the CCG average of 94% and the national average of 94%.

Privacy and dignity

Staff were highly motivated to offer kind, compassionate care that respected people's privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a barrier to the queue at reception where patients were asked to wait until called by the receptionist, giving the patients at reception space.
- 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.

Outstanding ☆

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The practice was in one of the more deprived areas of the country (in the third most deprived decile), and recognised the link between deprivation and poor health. They worked with the local county council, public health and citizens advice to set up social prescribing schemes to help patients.

- They promoted the Warmer Homes Scheme, which aimed to improve the energy efficiency and warmth of homes owned by people on low incomes. The practice was the pilot site for the local area; they identified high risk patients, for example those with chronic diseases such as asthma. Grants totalling £51,000 were awarded to 14 of their patients and funding and support given to allow patients to get better deals on energy tariffs, fuel debt advice and energy saving advice. Gas boiler grants, oil boiler grants and cavity wall insulation grants were made available. Some patients were also identified as being at risk and received a safety/wellbeing visit from the fire service.
- The practice participated in the Healthier and Wealthier scheme where free benefits and welfare advice was given to patients. The clinicians identified patients in need of advice and arranged a call-back with a trained adviser. As a result of this patients with a 'financial outcome' were on average £3,713 better off. Twenty patient's 'Warwick-Edinburgh' score (a tool used to assess patients' mental wellbeing) improved from an average of 2.38 to 3.25 (out of 5) after they had received the advice.

The practice organised and delivered services to meet patients' needs. They took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- The practice list had continually increased over the last ten years. In 2008 there were fewer than 3,000 patients, in 2015 the practice had 4,455 patients. This then increased in 2018 to 5,729. The practice had not advertised or patients and there were no major new housing developments nearby. They believed this was due to their positive reputation in the locality.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice provided many in house services this included a teledermatology service, getting dermatology advice where appropriate, reducing need for hospital attendance.
- The practice provided minor surgery including joint injections.
- The GPs offered patients appointments where they would deal with more than one problem per appointment.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- There were GP care home visits and pharmacist led visits for patients who had suffered falls.
- The practice worked with attached community staff employed by the local federation who visited older and vulnerable people.
- The practice was responsive to the needs of older patients, and offered GP home visits and urgent appointments for those with enhanced needs.
- The practice worked as a team to provide joined up holistic care for all patients.

People with long-term conditions:

- The specialist respiratory nurse had clinics or carried out home visits for more complex patients which reduced the need for hospital outpatient's appointments. They had worked intensively with 26 patients over the last year (these were patients who were housebound with chronic obstructive pulmonary disease (COPD) with high admission/ exacerbation rates), this reduced the need for secondary care input. Referral rates to respiratory secondary care continued to reduce. In 2016/2017 the rate was 35 patients. In 2017/ 2018 this was eight patients.

Are services responsive to people's needs?

- Nurses followed up heart failure and ischemic heart disease patients. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice ran a diabetes (care) ++ service. This was achieved through the nurse practitioner and GP undertaking extra training in diabetes care. They were competent in initiating insulin, enabling the practice to care for patients who were poor controlled and required insulin rather than referring them to secondary care. The diabetes specialist nurse and consultant did not need to attend the practice as often because of this. The practice had approximately 350 diabetic patients, of which 60 have not needed to be referred to secondary care due to the service at the practice.
- The diabetes specialist nurse attended the surgery every one to two months, whilst there they undertook a diabetes clinic with the nurse practitioner and the GP if required. The diabetes consultant attended the surgery on a three to four monthly basis. They ran a clinic with the nurse practitioner and GP reviewing patients who needed further input rather than referring to secondary care. The consultant also provided support and advice if needed and discussed any cases the staff needed further support with.
- Patients identified as being at risk of diabetes were managed by the nurse practitioner. Health care appointments were arranged and patients could be referred to a diabetes prevention programme.
- The practice had a higher prevalence of COPD at 5.6% compared to the national average of 1.7%. Their hospital admission rate for these patients however was low at 2.4 (per 1,000 diagnosed patients) compared to the clinical commissioning group (CCG) average of 4.3. The practice had achieved this by testing patients lung function with COPD and having nurse practitioner appointments available on the same day to complete an appropriate treatment plan. There was a new recall system in place for these patients where they were reviewed in the first six months of their plan to ensure problems are addressed and intermediate care given.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments and on-line access.
- There were many services offered at the practice for example, minor surgery and dermatology advice.

People whose circumstances 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 was involved in the production of a 'social story' for a young adult with autism to help them visit the GP. They provided individualised care for those with specific difficulties, for example an appointment when the surgery was quiet.
- One of the GPs carried out home visits for patients with learning difficulties to undertake their annual health checks.
- Military veterans were identified when registered with practice and advice given on links to support groups.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had local mental health services delivered in house. This was easier for the patients to access than secondary care.

Timely access to care and treatment

Outstanding ☆

Are services responsive to people's needs?

Patients were able to access care and treatment from the practice within good timescales 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.
- From the completed CQC comment cards patients reported that it was easy to obtain an appointment.
- Staff told us that the appointments system was very good and usually patients could obtain an appointment within a day or two. We confirmed this on the inspection day, as the next available routine appointment was in two working days.
- The National GP Patient Survey results on appointments and getting through to the surgery on the telephone were much higher than all of the local clinical commissioning group (CCG) and national averages. For example, the number of patients asked how easy is it was to get through to someone at the surgery on the phone, who responded positively, was 90% compared to the local CCG average of 76% and national average of 70%.

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.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

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

Leadership capacity and capability

The practice demonstrated compassionate culture and an inclusive and effective leadership. This was used to drive and improve the delivery of high-quality person-centred care. Leaders had the capacity and skills to deliver high-quality, sustainable care. They had an inspiring shared purpose, strived to deliver and motivated staff to succeed.

The practice provided good clinical care due to the effective and clear systems and processes put in place by the leadership. This was demonstrated by;

- Clinical audits completed and on-going.
- Performance figures for QOF, and prescribing data.
- Proactive management of long-term conditions.
- Patient and staff feedback and evidence of how they responded to it.
- Feedback from credible external bodies.
- A good accessible appointment system.
- Good engagement with the community and support for patients.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business meetings to achieve priorities.
- 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 care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice worked in partnership with many other organisations to link patients with other support organisations. For example, they promoted the Warmer Homes Scheme and they participated in the Healthier and Wealthier scheme.
- 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 had high levels of engagement with patients. They focused on their needs, they offered many services locally so that patients did not have to travel.
- 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 that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice was committed to training and development of staff and supporting the wider clinical community and ensuring it's sustainability.
- There were high levels of constructive staff engagement. 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. The GPs met everyday to discuss their everyday work and to support each other.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. Governance and performance management arrangements were proactively reviewed and reflected best practice.

- 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 co-ordinated person-centred care.

Outstanding ☆

Are services well-led?

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of 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 considered and understood the impact on the quality of care of service changes or developments.
- The practice was on the border of two hospital and clinical commissioning group (CCG) areas and they had plans in place to ensure that this did not impact on care to patients.

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 robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear approach to seeking out and embedding new ways of providing care and treatment.

- Innovative approaches of working with stakeholders to improve patient care.
- There was a focus on continuous learning and improvement. The practice taught medical students (from first to fifth year). The practice trained GP registrars. Students who were interested in a career in medicine gained work experience at the practice. A student from the previous year was now a medical student and another was training to become a paramedic.
- One of the GP partners was the GP lead for education for the local CCG and assisted in a career start scheme for GPs.
- The practice had supported a GP to return to general practice after long term ill health.
- The practice nurse was supported by the practice to study to become a prescriber, complete a diabetes diploma and to complete nurse practitioner training. They now led and arranged the monthly educational meetings in the surgery.
- The practice gave training to a pharmacist to work at the practice who completed their prescriber training with them.
- The practice received an award from the training company who facilitated apprenticeships for young

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people. It commended them for 'recognition of excellence' for supporting young people to be successful in employment and to get on the 'step' of the career ladder.

- The practice actively accessed social prescribing schemes to improve the quality of life for their more disadvantaged patients.

Please refer to the evidence tables for further information.