

Southdene Medical Centre

Quality Report

Front Street, Shotton Colliery, Durham, County
Durham, DH6 2LT
Tel: 0191 526 5818
Website: www.southdenemicalcentre.co.uk

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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?	Outstanding	
Are services effective?	Outstanding	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Outstanding	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Southdene Medical Centre on 24 November 2016. Overall the practice is rated as outstanding.

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

Patients were protected by a strong comprehensive safety system and there was a focus on openness, transparency and learning when things went wrong. The practice had a strong system in place for recording, monitoring and learning from significant events, accidents, complaints and reporting.

- The practice used innovative and proactive methods to improve patient outcomes. The practice had a high rate of clinical audit for their size.
- Outcomes for patients who use similar services were consistently better than expected when compared with similar services. Data showed that the practice was performing highly when compared to practices nationally and in the Clinical Commissioning Group. The latest publically available data from 2015/16

showed the practice had achieved the maximum points available to them for 2015/16 (100%), with a clinical exception rate of 8.2%. This was above the England average of 95.3%, and their clinical exception rate was below the England average of 9.8%.

- The practice used creative approaches to care and treatment and placed a strong emphasis on patient education. Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to meet the needs of the individual patients to ensure flexibility, choice and continuity of care.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- Patients could access appointments and services in a way that suited them. They said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a clear vision which had quality and safety as its top priority.
 - There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team.

We two areas of outstanding practice which were:

- The practice had all-encompassing systems and processes in place to ensure that patients received high quality care and treatment. These included

learning from significant events, triggering clinical audits and then changes in clinical practice which improved patient care. For example, One of the GP partners kept a folder of NICE guidance updates which they reviewed at clinical meetings to ensure they were followed and actioned. They took action as appropriate with regards to existing patients and updated templates and guidelines and protocols the practice had in place. The practice had structured tiered templates on the practice intranet system to obtain information on medical conditions to improve patient care.

- The practice placed a strong emphasis on patient education. In addition to the usual education provided to patients during regular appointments they arranged an education programme with diabetic patients with a local renal consultant in May 2016. The practice monitored the personal diabetes control of the patients who attended this session and found that 38% of patients who attended (eight) lost weight and improved the control of their diabetes.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as outstanding for providing safe services.

Patients were protected by a strong comprehensive safety system and there was a focus on openness, transparency and learning when things went wrong. The practice had a strong system in place for recording, monitoring and learning from significant events, accidents, complaints and reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was a genuine open culture in which all safety concerns were valued. The practice used opportunities to learn from internal and external incidents, to support improvement.

There were strong arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. For example, they regularly generated a report of children who missed appointments and of children who had injured themselves and attended the A & E department or out of hour's service, these would be reviewed to identify trends and warnings signs which led to further action. The safeguarding lead for the practice was a locality lead and had received a higher level of safeguarding training than other practice leads.

Risk management was well embedded and recognised as the responsibility of all staff. The practice was clean and hygienic and good infection control arrangements were in place. The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe.

Staff recruitment and induction policies were in operation and staff had received Disclosure and Barring Service (DBS) checks where appropriate. Chaperones were available if required and staff who acted as chaperones had undertaken appropriate training.

Outstanding



Are services effective?

The practice is rated as outstanding for providing effective services.

The practice had an effective system in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

Outcomes for patients who use similar services were consistently better than expected when compared with similar services. Data from the Quality and Outcomes Framework (QOF) showed that the practice was performing highly when compared to practices nationally and in the clinical commissioning group. The latest

Outstanding



Summary of findings

publicly available data from 2015/16 showed the practice had achieved the maximum points available to them for 2015/16 (100%), with a clinical exception rate of 8.2%. This was above the England average of 95.3% and the local clinical commissioning group (CCG) average of 97.5%. Their clinical exception rate was below the England average of 9.8%.

There was a system in place for clinical audit and the practice had a high rate of audit for their size. The practice had carried out nine, two cycle audits in the last twelve months.

The practice had been recognised locally over the years as having a good track record for the prescribing of medication. They were the second lowest prescribers of antibiotics in the locality out of 39 practices.

There was continuing development of staff skills, staff received appropriate training for their roles and appraisals and supervisions were carried out for all staff. The nurse practitioner had been supported to train for this role.

The practice's uptake for the cervical screening programme was 90%, which was above the national average of 82%. They told us it had been at a consistently high level since 2007 and it was the highest in the locality. In the past the practice had been asked by the local NHS cervical screening supporting office to give best practice advice to practices with lower screening uptake.

The practice placed a strong emphasis on patient education. In addition to the usual education provided to patients during regular appointments they arranged an education programme with diabetic patients with a local renal consultant in May 2016.

Are services caring?

The practice is rated as good for providing caring services.

Feedback from patients and those who completed CQC comment cards were overwhelmingly positive. Patients and staff gave us examples of where the practice had gone the 'extra mile'. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Data from the National GP Patient Survey showed scores from patients were variable compared to local and national averages. For example, 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.

Good



Summary of findings

There were 47 patients registered as a carer which was 2% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice had close links with the local carers' organisation.

The practice sent bereavement cards and a pack to family members on the death of a patient. Due to the size of the practice and the longevity of the GPs and practice staff they felt they were able to offer individualised care to patients as they knew their medical and social histories very well.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to meet the needs of the individual patients to ensure flexibility, choice and continuity of care.

Patients could access appointments and services in a way that suited them. Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day. The practice had very good access to appointments for patients. For example, results from the National GP Patient Survey showed that 96% of patients said they could get through easily to the surgery by phone compared to the local CCG average of 79% and national average of 73%.

The practice had developed services to understand the needs of different groups of patients. For example, patients with long term conditions were monitored very closely by the practice nurses, overseen by the GPs. The nurses had received training in many aspects of chronic disease management. The practice were keen to promote self-care to the patients to manage their conditions. Holistic appointments were available for patients where more than one condition could be reviewed and the reception staff had templates to ensure they booked an appointment long enough to suit patient need.

The practice building was purpose built and the design of the building was intended to give the practice a friendly feel rather than looking like a clinical building. They had recently extended it to include a room at reception for patients to be seen in private if necessary or for the room to be used for breast feeding. Disabled access was improved with new flooring and the lowering of the height of the reception desk.

Information about how to complain was available and easy to understand.

Good



Summary of findings

Are services well-led?

The practice is rated as outstanding for being well-led.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person centred care. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. They had a business plan in place with goals and objectives. This set out the arrangements for monitoring, and provided the evidence of how the practice demonstrated improved outcomes. High standards were promoted and owned by all practice staff and teams worked together across all roles.

Governance and performance management arrangements were continually reviewed and reflected best practice. The practice had a governance framework in place which supported the delivery of the business plan and good quality care. Data such as the Quality and Outcomes Framework (QOF) performance supported this.

There was constructive engagement with staff and a high level of staff satisfaction. For example, the nursing team told us that when the refurbishment of the practice was planned their wishes were taken into account regarding storage facilities. The practice had gathered views from the patient participation group (PPG) and had used them to improve the services provided.

The practice had a culture of continuous improvement. The leadership drove continuous improvement and staff were accountable for delivering change. They had systems and processes in place to improve clinical care and these were continually developing.

Outstanding



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as outstanding for the care of older people.

Nationally reported Quality and Outcomes Framework (QOF) data (2015/16) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, performance for atrial fibrillation related indicators were above the national average (100% compared to 96% nationally). The practice offered proactive, personalised care to meet the needs of the older people in its population.

The practice subscribed to a hospital admission avoidance direct enhanced service. There were care plans in place for at least the most vulnerable 2% of the practice population. There was a vulnerable adult's wrap around service provided by the CCG. This was provided by a nurse practitioner who visited the practice daily and would visit patients, mostly frail and elderly and those in care homes who the practice had concerns about.

All patients over the age of 75 had a named GP. The practice offered home visits. Prescriptions could be sent to any local pharmacy electronically. The practice had palliative care meetings every month where the practice shared information with palliative care nurses and district nurses ensuring they could provide holistic care to their patients.

Outstanding



People with long term conditions

The practice is rated as outstanding for the care of patients with long-term conditions.

Nationally reported QOF data (2015/16) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. The practice had received maximum points for all 19 clinical domain indicator groups, which included asthma, heart failure, diabetes and chronic obstructive pulmonary disease (COPD) related indicators.

The practice had a register of patient with long term conditions which they were proactive in their monitoring of for annual call and recall appointments for health checks by the nurses. Annual medication reviews were carried out by the practice nurses but reviewed by the GPs. Holistic appointments were available where patients could be reviewed for multiple long term conditions at their

Outstanding



Summary of findings

appointment, this meant they could be seen in relation to several different long-term conditions at the same time, saving time for the patient. Extended opening hours and home visits were available when needed.

Both of the nurses at the practice received training in many aspects of chronic disease management. This included the MERIT (Meeting, educational requirements, improving treatment) diabetes management programme, which the nurses and GPs attended. Following mentored clinics, the practice has been initiating insulin therapy in patients with type two diabetes, (19 patients since 2012). The practice team had ongoing annual diabetes training to keep up to date with changes. This decision was made after the patients expressed the wish to have their diabetes care delivered within the practice. Since this training referrals of patients with type two diabetes has reduced significantly. The practice offered open access to patients with diabetes receiving insulin via the telephone. Staff were trained in electrocardiogram (ECG) interpretation.

The nurses had received training in tissue viability and were competent in Doppler assessment and ankle brachial pressure index (ABPI) prior to applying compression dressings for patients. This service meant that referrals to secondary care were avoided and it allowed the patients to be seen in the community with familiar staff close to home.

Nurses had been caring for patients with leg ulcers since 2008. Appointments were offered to patients according to patient need, this may have been daily when ulcers are more active and less often throughout the healing process.

A practice audit showed that 14 patients had attended the practice for leg ulcer treatment in the surgery. One patient was seen over a six year period due to complex problems, backed up by advice from secondary care. Twelve patients had been seen with ulcers which had subsequently healed and care was completed. One patient had treatment ongoing.

The practice arranged an education programme with diabetic patients with a local renal consultant in May 2016. They talked to patients and their relatives. They explained about the treatments for diabetes and explained the possible complications of uncontrolled diabetes. The practice were monitoring if the personal diabetes control of the patients who attended would tighten following the presentation. The practice received positive feedback from those who attended who said it was beneficial to their understanding of their condition. There were plans for the coming year to have similar presentations regarding heart disease and respiratory problems including chronic obstructive pulmonary disease (COPD).

Summary of findings

Families, children and young people

The practice is rated as outstanding for the care of families, children and young people.

There were strong systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice regularly generated a report of children who missed appointments and of children who had injured themselves and attended the A & E department or out of hours service. These would be reviewed to identify trends and warnings signs which led to further action by the safeguarding lead for the practice. There were safeguarding meetings at the practice every three months.

Childhood immunisation rates for the vaccinations given were above CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under twelve months were 100%, compared to CCG averages of 98%. For five year olds from 97% to 100%, compared to CCG averages of 97% to 99%. The practice told us their child immunisation programme had been above 90% since 2009. The practice had a robust call and re-call system and would contact the family if necessary. There was a flexible appointment system for child immunisations.

The practice's uptake for the cervical screening programme was 90%, which was above the national average of 82%. They told us it had been at a consistently high level since 2007 and it was the highest in the locality. In the past the practice had been asked by the local NHS cervical screening supporting office to give best practice advice to practices with lower screening uptake. The practice said they believed the high uptake was due to their diligent call and re-call system. Administration staff would telephone patients and persist to encourage them to attend an appointment. The GP would personally contact patients to discuss the benefits of screening.

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had recently been updated to include a private room at reception which could be used for breast feeding.

Outstanding



Working age people (including those recently retired and students)

The practice is rated as outstanding for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Outstanding



Summary of findings

The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. There was a full range of health promotion and screening that reflected the needs for this age group.

Flexible appointments, including telephone appointments, were available as well as extended opening hours.

People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances. This included patients with a learning disability. Emergency contacts for patients were included in this register. This was particularly helpful with a patient with learning disabilities who needed emergency care in the surgery and admission to secondary care. This allowed the named contact from social services to be easily contacted.

The practice offered annual health checks and had an 86% attendance rate for this patient group. If the patient required a home visit the GP and nurse practitioner would visit the patient.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice's computer system alerted GPs if a patient was a carer. There were 47 patients registered as a carer which was 2% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice had close links with the local carers' organisation.

Outstanding



People experiencing poor mental health (including people with dementia)

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The community psychiatric nurse visited the practice once a week to provide care for patients.

Outstanding



Summary of findings

The practice maintained a register of patients experiencing poor mental health and recalled them for at least an annual review. There were care plans in place for those with severe mental health conditions.

Patients with dementia were reviewed annually and offered a care plan in relation to their condition. Patients were told how to access various support groups and voluntary organisations. Performance for mental health related indicators was better than national average. For example, performance for dementia indicators was above the national average (100% compared to 92.8% nationally).

Summary of findings

What people who use the service say

We spoke with four patients on the day of our inspection; they were all members of the practice's patient participation group (PPG). They all were very positive about the service they received from the practice. Common words used included excellent and caring family practice. They said they could obtain an appointment when they needed one.

We reviewed 45 CQC comment cards completed by patients prior to the inspection. All were wholly positive. Common words used were exemplary service, excellent, caring and friendly. Some patients described how they thought the staff went the 'extra mile' for patients, for example, in times of serious illness or bereavement. Patients said that they could access appointments when they needed them.

The latest GP Patient Survey, published in July 2016, showed that scores from patients were comparable with national and local averages for satisfaction with care and treatment; they were above averages for patient experience of making an appointment. The percentage of patients who described their overall experience as good was 88%, which was comparable with the local clinical commissioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 82% (local CCG average 83%, national average 80%).
- 88% said the GP was good at listening to them compared to the local CCG average of 89% and national average of 87%.
- 90% said the GP gave them enough time compared to the local CCG average of 89% and national average of 87%.
- 93% said the nurse was good at listening to them compared to the local CCG average of 94% and national average of 91%.
- 94% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 96% said they found it easy to get through to this surgery by phone compared to the local CCG average 79%, national average 73%.
- 87% described their experience of making an appointment as good compared to the local CCG average 77%, national average 73%.
- 89% of patients found the receptionists at this surgery helpful compared to the local CCG average 89%, national average 87%.

These results were based on 108 surveys that were returned from a total of 356 sent out; a response rate of 30.3% and 3.9% of the overall practice population.

Outstanding practice

- The practice had all-encompassing systems and processes in place to ensure that patients received high quality care and treatment. These included learning from significant events, triggering clinical audits and then changes in clinical practice which improved patient care. For example, One of the GP partners kept a folder of NICE guidance updates which they reviewed at clinical meetings to ensure they were followed and actioned. They took action as appropriate with regards to existing patients and updated templates and guidelines and protocols the

practice had in place. The practice had structured tiered templates on the practice intranet system to obtain information on medical conditions to improve patient care.

The practice placed a strong emphasis on patient education. In addition to the usual education provided to patients during regular appointments they arranged an education programme with diabetic patients with a local renal consultant in May 2016. The practice monitored the personal diabetes

Summary of findings

control of the patients who attended this session and found that 38% of patients who attended (eight) lost weight and improved the control of their diabetes.

Southdene Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Southdene Medical Centre

Southdene Medical Centre provides Primary Medical Services to the villages of Shotton Colliery, Haswell, the town of Peterlee and the surrounding areas from Southdene Medical Centre, Front Street, Shotton Colliery, County Durham, DH6 2LT.

There are also two branch surgeries;

- Peterlee Health Centre, County Durham, SR8 1AD
- Front Street (East), Haswell, County Durham, DH6 2BL.

We inspected the branch surgery at Peterlee Health Centre on the inspection day in addition to the main surgery at Shotton Colliery.

Southdene Medical Centre provides services to approximately 2,900 patients of all ages. The practice is commissioned to provide services within a Personal Medical Services (PMS) contract with NHS England.

The surgery is located in purpose built premises, which have been extended over the years to accommodate the services provided. There is step free access at the front of the building and all patient facilities are located on the ground floor with full disabled access. There is a car park with disabled spaces available.

The branch surgery at Haswell is located in shared premises with another local practice. The branch surgery at Peterlee is based in Peterlee Health Centre, the practice has its own consulting rooms and the building is shared with six other practices.

The practice has two GP partners and one salaried GP, two female and one male. Two of the GPs work part-time and the whole time equivalent (WTE) of GPs is 2.3. There is a nurse practitioner and a part-time practice nurse (WTE 0.7) and one healthcare assistant. There is a practice manager, four administration staff and one domestic assistant.

The practice is part of NHS Durham Dales, Easington and Sedgefield clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the second most deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

Southdene Medical Centre is open from 8am until 6pm Monday to Friday, with extended opening times on Monday evening until 8pm. Consulting times are broadly from 9am until 12noon or 1pm and then 3pm until 5pm. On extended opening days consulting times are 6.30pm until 8pm.

Peterlee branch surgery opening and consulting times are Monday to Wednesday and Friday 9am until 10:30am. The branch was open Saturday mornings 8am until 12 noon.

Haswell branch surgery opening and consulting times are;

- Monday 12:45pm until 2pm – nurse
- Wednesday 11am until 1pm - GP
- Friday 9am until 11am – nurse practitioner

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 24 November 2016.
- Spoke with staff and patients who provide and receive services.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.



Are services safe?

Our findings

Safe track record and learning

Patients were protected by a strong comprehensive safety system and there was a focus on openness, transparency and learning when things went wrong. The practice had a strong system in place for recording, monitoring and learning from significant events, accidents, complaints and reporting. Significant events were prioritised according to category, clinical and non-clinical and were discussed with all members of the multi-disciplinary team meeting (MDT) at practice meetings this included palliative care nurses, dieticians, safeguarding lead midwives and health visitors.

The practice manager had overall responsibility for the collation of significant events. They maintained a schedule of these, there had been 16 in the last 12 months. Where incidents and events met the threshold criteria, these were added to the local clinical commissioning group (CCG) Safeguard Incident & Risk Management System (SIRMS).

There was good sharing of significant events with outside organisations. For example, when the practice received hospital letters which related to the incorrect patient they ensured the hospital followed this up. We saw that significant events were discussed at practice team meetings from minutes supplied to us. There was an annual review of significant events.

The surgery changed procedures as a result of a significant event. A patient had not received an appointment for a follow-up colonoscopy. Although it was the hospital who failed to recall the patient, the practice devised a process for the administration team to monitor that the follow up appointment had been made.

Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. They gave us examples of feedback from recent incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. There was a comprehensive system in place to manage the safety alerts. One of the GP partners was the designated

lead in the practice to manage this process. They determined what action was necessary and acted accordingly. All alerts were stored in a folder. There was a spreadsheet which documented what action had been taken and any searches on the practice computer system were recorded there. Alerts were a standing agenda item at the practice meeting and actions were documented in the minutes and carried forward to the next meeting.

Overview of safety systems and processes

The practice could demonstrate a safe track record through having comprehensive systems in place for safeguarding, health and safety, including infection control, and staffing.

- There were strong arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the practice GP partners was the lead for safeguarding adults and children.
- Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of.

There were safeguarding meetings every three months where the midwife, health visitor and school nurses attended or safeguarding matters were reviewed earlier where appropriate, learning was disseminated to all staff. The practice were able to give examples where receptionists had appropriately identified and acted upon safeguarding issues. They had all received safeguarding children and adults training relevant to their role. The safeguarding lead had received level three safeguarding children training.

- There were notices displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses and some of the reception staff carried out this role. They had all received chaperone training. All staff who carried out chaperone duties 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).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and



Are services safe?

tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the infection control lead. There were infection control policies, including a needle stick injury policy. Infection control audits were carried out every three months, where actions needed to be completed they were carried out. A legionella risk assessment had been carried out and regular checks of the water were carried out. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling.) Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out regular medicines audits, with the support of the local CCG pharmacist who visited fortnightly. There were good arrangements in place to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out and records were well organised. We sampled recruitment checks for both staff and GPs, including locums, and saw that checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. We saw that the clinical staff had medical indemnity insurance.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were comprehensive procedures in place for monitoring and managing risks to patients and staff

safety. The staff at the practice had all been trained in health and safety. One of the GP partners explained that the practice partners were meticulous in ensuring that the buildings were fit for purpose and a refurbishment had just been completed at the Southdene surgery. The management team had consulted with the patient participation group and the staff regarding the refurbishment. The practice manager showed us the practice health and safety information which included, fire and health and safety policies and risk assessments for each surgery, fire equipment checks and the fire evacuation report. There were regular fire drills at each site. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a proactive approach to anticipating and managing risks to patients, they rarely used locum cover.

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. The practice took an opportunity to learn from an external safety event and began to stock adrenaline pens in their stock of emergency medicines instead of adrenaline in the form of vials. Following resuscitation training this was discussed at a clinical meeting and the decision was made to purchase these (both adult and children's dosage) as the practice considered them to be safer for treatment of patients.

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.



Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. One of the GP partners kept a folder of NICE guidance updates which they reviewed at clinical meetings to ensure they were followed and actioned. For example new guidelines regarding atrial fibrillation and cancer had been actioned. They took action as appropriate with regards to existing patients and updated templates, guidelines and protocols the practice had in place. The practice had structured tiered templates on the practice intranet system to obtain information on medical conditions to improve patient care. They subscribed to a hospital admission avoidance direct enhanced service. There were care plans in place for at least the most vulnerable 2% of the practice population. At the time of the inspection a report ran on the practice computer system showed that no medication prescribed was in conflict with NICE guidance for any patients.

A clinical data audit of patient records was carried out by the practice manager every month, by selecting notes from random patients. They ensured the notes had a journal entry attached to each appointment and that they were appropriate and correctly recorded. The findings were constantly positive with little improvement required.

Management, monitoring and improving outcomes for people

Outcomes for patients who use similar services were consistently better than expected when compared with similar services. The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice closely monitored the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. They provided us with their monitoring reports which they used called 'How am I driving'.

The latest publicly available data from 2015/16 showed the practice had achieved 100% of the total points available to them which was above the local CCG average of 97.5%, and

a national average of 95.3%, with an overall exception reporting rate of 8.2%, which was below the England average of 9.8%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The data for 2015/16 showed that the practice had received maximum points for all 19 clinical domain indicator groups, which included asthma, dementia, heart failure and mental health indicators.

All staff were actively engaged with activities to monitor and improve quality and outcomes. The practice provided us with a folder of clinical audits and prescribing reviews on the inspection day to demonstrate the work they had carried out. There were nine in the last twelve months; they were all two cycle audits. These were triggered by new clinical guidance, significant events, personal interest, changes in prescribing practice and monitoring of effectiveness.

There was an audit carried out looking at medicines used to treat urinary tract infections. The practice were able to demonstrate quality improvement in all of the targets set by the audit. For example, clinical symptoms documented improved by 80%, being treated empirically increased by 20% and dip stick testing increased by 22%. Other topics of the audits included the combined oral contraceptive pill, patient's body mass index (BMI), medication used to treat high blood pressure, the use of a pain medication, use of diamorphine in GPs bags and a controlled drug audit. This was a high rate of clinical audit, for the size of the practice, which was linked to improvement of patients' outcomes.

The practice prided themselves on their prescribing track record. They were the second lowest prescribing practice of antibiotics out of 39 others in the locality. NICE guidance recommends that GPs should not over prescribe this type of medication. There were plans to carry out an audit on the prescribing of antibiotics in the coming year to promote awareness and prescribing best practice. The practice were also low prescribers of high-risk medication such as nonsteroidal anti-inflammatory medications (NSAIDs) which are used for pain relief. The practice was recognised by the CCG as being a leader in the management of prescribing. They provided us with letters they had received going back some years from the CCG and preceding organisations praising the quality of the practice's prescribing.



Are services effective?

(for example, treatment is effective)

The practice provided us with data from NHS England commissioning support group which demonstrated that the referrals for the practice for general and acute referrals to hospital were down 13% this financial year (2016/17) compared to the same period the previous year (2015/16). They had been invited by demand management from the CCG to review hospital referrals for paediatrics and gynaecology. This was two specialties the practice was seen to be high in referring. This allowed review of individual referrals within the practice to highlight how appropriate referrals were.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. There was also an up to date locum induction pack at the practice.

The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. All staff had received an appraisal within the last twelve months. We saw examples of these. Staff told us they felt supported in carrying out their duties. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. For example, the nurse practitioner had started at the practice as a practice nurse and had been encouraged and mentored to become a nurse practitioner. A member of the reception team was mentored and encouraged to develop their skills to become a health care assistant.

- All GPs in the practice had undertaken revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.)
- Staff received training that included: fire and health and safety, equality and diversity, basic life support, safeguarding children and adults, infection control and information governance awareness. Clinicians and practice nurses had completed training relevant to their role.

Coordinating patient care and information sharing

The practice had effective and well established systems to plan and deliver care and treatment. Patient information was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example, when people were referred to other services.

The practice had palliative care multi-disciplinary (MDT) meetings every month where the practice shared information with palliative nurses and district nurses ensuring they could provide holistic care to the patients. The salaried GP had completed a certificate in palliative care at a local university. The meeting allowed the community team to share information regarding patients, to ensure their care was of the highest standard whilst remaining personal to each patient. Issues regarding housing, medication and pain relief were often discussed and improvements could be made for the patient and for their family, during the illness. The experience of the attendees at the monthly meeting allowed triangulation of information and sharing of best practice from the viewpoints of different team members. All deaths of patients were reviewed to ensure any learning from these could be taken forward.

There were quarterly safeguarding meetings with attendance from the health visitor, district nurse and school nurse.

A system was in place which the practice devised to ensure that the GPs and administration team communicate effectively when hospital letters were received. The template ensured the GPs read the letter and recorded the actions they would like the administration team to carry out.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements and had received training in relation to this, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse



Are services effective? (for example, treatment is effective)

assessed the patient's capacity and recorded the outcome of the assessment. We saw an example of a consent form. One of the GP partners had recently attended an update on the mental capacity act and was to disseminate the information at the next practice meeting.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 90%, which was above the national average of 82%. They told us it had been at a consistently high level since 2007 and it was the highest in the locality. In the past the practice had been asked by the local NHS cervical screening supporting office to give best practice advice to practices with lower screening uptake. The practice said they believed the high uptake was due to their diligent call and re-call system. Administration staff would telephone patients and persist to encourage them to attend an appointment. The GP would personally contact patients to discuss the benefits of screening. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening; the GPs sent letters to the patients if they failed to respond. The practice carried out an audit on bowel screening, the results showed that the did not attend rate (DNA) was high. This resulted in a new policy of the lead GP sending a letter to all patients reinforcing the importance of bowel screening.

Childhood immunisation rates for the vaccinations given were above CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under twelve months were 100%, compared to CCG averages of 98%. For five year olds from 97% to 100%, compared to CCG averages of 97% to 99%. The practice told us their child immunisation programme had been above 90% since 2009. The practice had an effective call and re-call system and would contact the family if they failed to attend. There was a flexible appointment system for child immunisations.

The practice used creative approaches to care and treatment and placed a strong emphasis on patient education. . In addition to the usual education provided to patients during regular appointments they arranged an education programme with diabetic patients with a local renal consultant in May 2016. They talked to patients and their relatives. They explained about the treatments for diabetes and the possible complications of uncontrolled diabetes. The practice monitored the personal diabetes control of the patients who attended this session and found that 38% of patients who attended (eight) lost weight and improved the control of their diabetes. The practice received positive feedback from those who attended who said it was beneficial to their understanding of their condition. There were plans for the coming year to have similar presentations regarding heart disease and respiratory problems including chronic obstructive pulmonary disease (COPD).

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the nurse or healthcare assistant if appropriate.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that they were treated with dignity and respect.

- Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

We reviewed 45 CQC comment cards completed by patients prior to the inspection. All were wholly positive. Common words used were exemplary service, excellent, caring and friendly. Some patients described how they thought the staff went the 'extra mile' for patients, for example in times of serious illness or bereavement. We spoke with four patients on the day of our inspection. They all were very positive about the service they received from the practice. Common words used included excellent, family practice and caring.

Results from the National GP Patient Survey, published in July 2016, for how patients felt they were treated with compassion, dignity and respect were variable compared with local and national satisfaction scores on consultations with doctors and nurses. For example, of those who responded:

- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 89% said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

The practice provided us with examples of caring acts which had occurred at the practice, for example, one of the GPs and practice nurses travelled 45 minutes to visit a patient who had sustained a severe stroke and was in hospital.

The practice were involved in a project working with an outside agency to identify patients with respiratory conditions who may have benefitted from a new heating system in their homes. Twenty six patients were referred to the project and fourteen of these had new heating systems fitted to their homes.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey showed patients' responses were variable when compared to local and national averages regarding their involvement in planning and making decisions about their care and treatment: For example, of those who responded:

- 88% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 93% said the last nurse they spoke to was good listening to them compared to the CCG average of 94% and the national average of 91%.
- 94% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

Staff told us that translation services were available for patients who did not have English as a first language.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations and there was a good range of leaflet information available in the waiting area. This included information for patients who were carers.

The practice's computer system alerted GPs if a patient was a carer. There were 47 patients registered as a carer which

was 2% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice had close links with the local carers' organisation.

The practice sent bereavement cards and a pack to family members on the death of a patient. Due to the size of the practice and the longevity of the GPs and practice staff they felt they were able to offer individualised care to patients as they knew their medical and social histories very well. The practice provided us with a folder of thank you cards which they had received from patients and their families. These had been sent particularly after bereavements in the family.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to meet the needs of the individual patients to ensure flexibility, choice and continuity of care.. For example, the practice was involved in the CCG led prescribing incentive scheme. They had selected three mini audit topics.

The main practice building at Shotton Colliery was purpose built and the design of the building was intended to give the practice a friendly feel rather than looking like a clinical building. The GPs told us that they had continually provided the funds to keep the building updated and had recently extended it to include a room at reception for patients to be seen in private if necessary or for the room to be used for breast feeding. Disabled access was improved with new flooring and the lowering of the height of the reception desk. Improvements had been carried out following consultation with staff and patients to gain their views of what was required. The practice had a kiosk available to patients in their reception area, this is so that the patients can have privacy to complete surveys.

There was a proactive approach to understanding the needs of different groups of people. For example. The practice had a register of patient with long term conditions which they were proactive in their monitoring of for annual call and recall appointments for health checks by the nurses. Annual medication reviews were carried out by the practice nurses but reviewed by the GPs. Holistic appointments were available where patients could be reviewed for multiple long term conditions at their appointment; this meant they could be seen in relation to several different long-term conditions at the same time, saving time for the patient.

Both of the nurses at the practice received training in many aspects of chronic disease management. This included the MERIT (Meeting, educational requirements, improving treatment) diabetes management programme, which the nurses and GPs attended. Following mentored clinics, the practice has been initiating insulin therapy in patients with type two diabetes, (19 patients since 2012). The practice team had ongoing annual diabetes training to keep up to date with changes. This decision was made after the patients expressed the wish to have their diabetes care

delivered within the practice. Since this training referrals of patients with type two diabetes has reduced significantly. The practice offered open access to patients with diabetes receiving insulin via the telephone. Staff were trained in electrocardiogram (ECG) interpretation.

The nurses had received training in tissue viability and were competent in Doppler assessment and ankle brachial pressure index (ABPI) prior to applying compression dressings for patients. This service meant that referrals to secondary care were avoided and it allowed the patients to be seen in the community with familiar staff close to home.

Nurses had been caring for patients with leg ulcers since 2008. Appointments were offered to patients according to patient need, this may have been daily when ulcers are more active and less often throughout the healing process.

A practice audit showed that 14 patients had attended the practice for leg ulcer treatment in the surgery. One patient was seen over a six year period due to complex problems, backed up by advice from secondary care. Twelve patients had been seen with ulcers which had subsequently healed and care was completed. One patient had treatment ongoing.

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

- Telephone consultations were available if required.
- Booking appointments with GPs and requesting repeat prescriptions was available online.
- Home visits were available for housebound patients or those who could not travel to the surgery.
- Specialist Clinics were provided including minor surgery, joint injections, IUD, also known as coil) fitting and removal service, contraceptive implant and travel vaccinations.
- All patient services were accessible to patients with physical disabilities. Other reasonable adjustments were made and action was taken to remove barriers when people found it hard to use or access services.

Access to the service

Patients could access appointments and services in a way that suited them. Southdene Medical Centre was open from 8am until 6pm Monday to Friday, with extended

Are services responsive to people's needs?

(for example, to feedback?)

opening times on Monday evening until 8pm. Consulting times were broadly from 9am until 12noon or 1pm and then 3pm until 5pm. On extended opening days consulting times were 6.30pm until 8pm.

Peterlee branch surgery opening and consulting times were Monday to Wednesday and Friday 9am until 10:30am. The branch was open Saturday mornings 8am until 12 noon.

Haswell branch surgery opening and consulting times were;

- Monday 12:45pm until 2pm – nurse
- Wednesday 11am until 1pm GP
- Friday 9am until 11am – nurse practitioner

We spoke with four patients who said they had no problems in obtaining an appointment. From the 45 CQC comment cards completed, patients said that they could access appointments when they needed them.

Results from the National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment were mostly higher than local and national averages. For example;

- 96% of patients said they could get through easily to the surgery by phone compared to the local CCG average of 79% and national average of 73%.
- 87% of patients described their experience of making an appointment as good compared to the local CCG average of 77% and national average of 73%
- 80% of patients were satisfied with the practice's opening hours compared to the local CCG average of 79% and national average of 76%.

- 61% of patients said they usually waited 15 minutes or less after their appointment time to be seen compared to the local CCG average of 69% and national average of 65%.

The reception staff at the practice were provided with appointment templates which allowed them to book the correct length of time for the required appointment. None of the clinics were at set times, the baby clinic was once a fortnight but if patients were unable to attend at that time they could book an appointment at a time which suited them.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. There were routine appointments to see a GP in three working days and emergency appointments available that day. The reception staff told us there were also appointments available on the day if the patients rang on a morning and the GPs would fit extra appointments in at the end of surgery if necessary; they thought that patient access was very good.

Listening and learning from concerns and complaints

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 the designated responsible person who handled all complaints in the practice. There was a dedicated practice specific complaint leaflet available at reception and similar information in the practice information leaflet. There had been no complaints in the last twelve months at the practice.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a mission statement which was to provide an appropriate and rewarding experience for their patients whenever they needed their support, treating patients with compassion, dignity and respect. The practice told us they had prided themselves on providing high quality medicine in a traditional family practice. They believed they were respected by their peers and had built a positive relationship with consultant colleagues in secondary care.

The practice had a business plan in place with goals and objectives in place which linked to the monitoring of their performance, and taking action where needed. For example;

- A folder of clinical audits completed and ongoing.
- A comprehensive system of keeping up to date with NICE guidance.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

Governance and performance management arrangements were continually reviewed and reflected best practice. The practice had a governance framework in place which supported the delivery of the business plan and high quality person centred care. Data such as the Quality and Outcomes Framework (QOF) scores supported this. This ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities;
- There were comprehensive arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice manager carried out a monthly audit of patient records to ensure information had been appropriately recorded.

- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- Practice specific policies were implemented and were available to all staff.
- There were effective arrangements in place to manage areas such as long term conditions by the practice nurses who were overseen by the GPs.
- The GP partners and staff had a comprehensive understanding of the performance of the practice. For example they could demonstrate that the referrals for the practice for general and acute referrals to hospital were down 13% this financial year (2016/17) compared to the same period the previous year (2015/16).
- The practice worked with other organisations to achieve best value for money, for example they were the second lowest prescribing practice of antibiotics out of 39 others in the locality and worked with the CCG to achieve this.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. There was a holistic approach to patients using the service. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff. They said they felt the practice went the extra mile to provide a good service to patients and were proud to be part of it. There were high levels of staff satisfaction.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were multi-disciplinary meetings held every month for palliative care and every three months for safeguarding. There were attended by attached staff. There were monthly staff meetings where significant events, complaints, safety alerts and NICE guidance were discussed and actions carried forward. We saw minutes from these meetings.

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

Are services well-led?

Outstanding



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

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

The practice were well prepared for the inspection day. They had produced an information pack for all staff to explain what the inspection entailed and discussed the process at staff meetings. This was done to reduce staff anxiety and ensure they presented the information in the best way.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through patient surveys and the practice participation group (PPG).

The practice had a PPG with approximately 24 members who met quarterly (0.8% of the practice population). The meeting was led by the lead GP and nurse practitioner and was also attended by other members of staff. We saw minutes of the meetings. We spoke with four members of the PPG, they praised the practice and said they provided 'good old fashioned care'. They told us the practice were open to suggestions from the group. The group had influenced the practice in having the car park upgraded with new lighting and marked disabled bays. They were involved in decision making regarding the practice keeping oxygen and a nebuliser on site which was subsequently obtained for emergency use. The PPG were involved in surveys which the practice had carried out. Transport was provided to patients who would otherwise find it difficult to attend the PPG meetings and lunch was made available to all attendees.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The nursing team told us that when the refurbishment of the practice was planned their wishes were taken into account regarding storage facilities. They were able to be involved in the planning of a single storage area for all stock which helped them to ensure a more efficient way to monitor expiry dates.

Continuous improvement

The leadership drove continuous improvement and staff were accountable for delivering change. The GPs demonstrated a strong commitment to continuous learning and improvement at all levels within the practice. The practice was forward thinking in its approach. For example;

- The practice used every opportunity to learn from internal and external incidents, to support improvement.
- Information about safety was valued and was used to promote learning and improvement. There was a high level of clinical audit for the size of the practice.
- Systems and processes to improve clinical care were developed with further ideas for on-going progress. For example further consultant led education events for patients.
- The practice were continually developing their premises to support further improvements for the practice. The recent building work meant the practice could now consider their options for extending the GP team and becoming a training practice.