Ramsbury & Wanborough Surgery

Inspection report

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Ramsbury
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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?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as Outstanding overall.

(Previous inspection February 2016 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Ramsbury & Wanborough Surgery on 10 May 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. Learnings from incidents were also shared with the wider locality and improvements implemented across the locality.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided at all levels and it ensured that care and treatment was delivered according to evidence- based guidelines.
- Patient outcomes were continually improving with the introduction of innovative programmes of care.
- Staff involved and treated patients with compassion, kindness, dignity and respect. Patient feedback was consistently positive across all aspects of care.
- Patients found the appointment system easy to use and reported that they could access care when they needed it. Routine appointments were available within a few days of requesting one.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw several areas of outstanding practice:

- Significant events were shared with the wider locality in order that sustained improvements in safety were implemented for the benefit of all patients in the area. This had been effective when an error was made in the dosage of a blood thinning medicine following blood testing by the community team. It was recognised that practices in the locality were all following different procedures. The practice took the opportunity to raise this with five other practices at a locality meeting. To minimise the risk of re-occurrence the practice led on introducing, a standard proforma which all practices in the locality were now using.
- The practice had initiated a scheme whereby the locality practices worked together to care for patients admitted to local nursing homes as an alternative to a hospital admission. Since its inception in 2015, 79 patients had been admitted to nursing home beds rather than hospital and only six of these had subsequently needed secondary care admission. Not only had this service reduced hospital admissions but patients were able to remain local to their family and support networks.
- The practice had implemented a range of initiatives to improve the management of long term conditions. Examples of this were the leg ulcer clinic, which had reduced onward referrals to the tissue viability service and healing times. One patient had been receiving treatment for 12 months prior to the initiation of the leg clinic. The ulcer was healed within six weeks of attending the leg clinic. The practice had taken part in the National Diabetes Audit which enabled the practice to benchmark themselves against other practices in the local clinical commissioning group and nationally. The practice had used these results to adapt and shape improved services for patients diagnosed with

Overall summary

diabetes. The practice had recently received the most recent audit results which demonstrated significant improvements in the three target areas of patients living with Type 1 diabetes. Within the Wiltshire Clinical Commissioning Group (CCG) the practice had improved from 46th to 13th place. The practice was one of only two practices in the locality who had increased performance for patients living with Type 2 diabetes.

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 and a practice manager specialist adviser.

Background to Ramsbury & Wanborough Surgery

Ramsbury Surgery is a purpose built medical centre in the village of Ramsbury. The village is nine miles from the town of Marlborough in Wiltshire and is very rural. The practice also has a branch surgery in the village of Wanborough, also in Wiltshire.

Services are provided from;

Rmmsbury Surgery, Whittonditch Road, Ramsbury, Marlborough, Wiltshire, SN8 2QT

and

Wanborough Surgery, 3-5 Ham Road, Wanborough, Swindon, Wiltshire, SN4 0DF.

We only visited the main site in Ramsbury during this inspection. Both practice locations offer a dispensary service.

The practice registered population is drawn from rural locations covering 180 square miles. Approximately 9,000 patients are registered with the practice.

Patients can attend either the main practice in Ramsbury or the branch practice at Wanborough. Around 2,500 of the registered patients prefer to use the Wanborough practice because it is closer to their homes. Data from Public Health England shows that the practice has a similar data profile to local and national figures for all age groups. This data also shows that the practices highest number of patients is in the over 65 years age range. The index of multiple deprivation shows the practice to be in the least deprived centile.

There are four GPs partners at the practice. The partners are supported by two salaried GPs (female), four practice nurses, two health care assistants and an administrative team led by the practice manager. The practice is a training practice for medical students, nursing students and qualified doctors. When the practice is closed patients are directed via the practice website to NHS 111. Out of hours services are provided by the Medvivo.

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

Risks to patients

There was a proactive approach to anticipating and managing risks to people who use the service and this was embedded and recognised as the responsibility of all staff.

- 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. This was demonstrated by a positive outcome when an acutely ill child was brought to the surgery. 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. The timeliness and efficiency of referrals had recently been further improved by the purchase of voice recognition software.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- 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.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice 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 it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. All staff were encouraged to participate in learning and to improve safety as much as possible.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. Innovation was encouraged to achieve sustained improvements in safety. For example, there had been an error in the dosage of a blood thinning medicine following blood testing by the community team. It was recognised that practices in the locality were all following a different procedure. The practice took the opportunity to raise this with five practices at a locality meeting To minimise the risk of re- occurrence the practice led on introducing, a standard proforma which all practices in the locality were now using.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice and all the population groups as outstanding.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

Effective needs assessment, care and treatment

There was a truly holistic approach when assessing, planning and delivering care and treatment to people who used the service. 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. A fortnightly meeting was held where there was a focus on a specific clinical topic that was presented by one of the practice clinicians and discussed by the practice.

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

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Staff were committed to working collaboratively for patients who had complex needs to ensure care was coordinated and patient centred. For example, integrated team clinics for the frail elderly, were designed to allow a one-hour appointment to see the Nurse Practitioner, GP and Care Co-ordinator.
- The practice followed up on older patients discharged from hospital. It ensured that 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.
- To reduce hospital admissions and to ensure patients remained close to their families and support network the practice had initiated a scheme whereby patients were admitted to a local nursing home bed rather than admitted to hospital. The practice had been actively monitoring the impact that this initiative had had on reduction of hospital admission rates. Of the 79 patients admitted to a nursing home as alternative to hospital only six had subsequently needed referral on to secondary care.
- The practice had achieved high rates of immunisation for patients who were eligible for a shingles vaccine. The practices rate of immunisation for this was over 20% higher than the national average. The systems in place that the practice had, to support this high uptake, had been shared with Public Health England in order that learns could be disseminated to improve uptake elsewhere.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- QOF data demonstrated that the practice performed significantly better for patients diagnosed with a respiratory condition when compared to local and national averages.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice had purchased a smart phone app that enabled them to quickly and effectively diagnose an abnormal heart rhythm whilst on home visits. The practice had identified and monitored how many patients this had improved efficiency of diagnosis or ruling out of this condition.

Outstanding ☆

Are services effective?

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- The latest results of the National Diabetes Audit 2016 -2017 demonstrated significant improvements in patients living with diabetes during the past year. The most recent audit results which demonstrated significant improvements in the three target areas of patients living with Type 1 diabetes. Within the Wiltshire Clinical Commissioning Group (CCG) the practice had improved from 46th to 13th place. The practice was one of only two practices in the locality who had increased performance for patients living with Type 2 diabetes.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were significantly higher (98%) than the target percentage of 90% or above for children aged two years old.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 79% which was comparable with the 80% coverage target for the national screening programme and slightly higher than the local average of 76% and national average of 72%. The practice had identified that cervical screening rates were low for women aged 25 to 35 years old. The 41 patients who had not responded to invites were proactively contacted by the practice. This resulted in 25% of these women attending for cervical screening.
- The practices' uptake for breast and bowel cancer screening was in line 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. To improve uptake, the practice had employed an additional staff member whose focus was to target this area. In the most recent quarter 183 patients were eligible for a NHS health check and 129 patients had attended demonstrating a 70% uptake. 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 those with a learning disability. The practice had 16 patients on their learning disabilities register. Patients were invited for health checks and these were conducted at the practice or in the patient's home.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- 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 all staff were actively engaged in routinely reviewing the effectiveness and

Are services effective?

appropriateness of the care provided. For example, appropriate prescribing of antibiotics. An initial audit demonstrated that appropriate prescribing of these medicines was 69%. A follow up audit showed that appropriate prescribing had improved to 91%.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had taken part in the National Diabetes Audit which enabled the practice to benchmark themselves against other practices in the local clinical commissioning group and nationally. The practice had used these results to adapt and shape improved services for patients diagnosed with diabetes.

Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care.

- 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. Monthly educational meetings were held at the practice to which colleagues across the locality were invited. These meetings improved communication between primary and secondary care and resulted in a positive impact on the referral process.
- Staff were proactively supported to acquire new skills, share best practice, encouraged and given opportunities to develop. For example, a nurse had undertaken training to fit contraceptive implants and devices and the nurse who ran the leg clinic invited nurses from other practices to a quarterly education session to share best practice and ensure they did not become deskilled.
- 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 induction process for healthcare assistants included the requirements of the Care Certificate. 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.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care that were coordinated across services and supported integrated care for people who used the service.

- 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. The 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.
- 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 supporting patients to live healthier lives through a targeted approach to health promotion and prevention of ill health.

Outstanding ☆

Are services effective?

- The practice identified patients who may need extra support and directed them to relevant services. This included patients receiving end of life care, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes and educational evenings for patients.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for caring.

People were truly respected and valued as individuals and were empowered as partners in their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- There was a strong ethos of person centred care.
- Responses from the GP survey demonstrated significantly better results when compared to national figures, specifically relating to nursing care and whether the practice would be recommended to others.
- Feedback we received on the day of the inspection from patients and comment cards was continually positive about the way staff treated people.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information 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. An annual road show and regular coffee afternoons were held for carers. The practice focus going forward was to improve identification of carers who were registered patients with the practice. The practice called carers on a quarterly basis if they had not attended the practice for some time. The practice had been awarded a Gold Plus award by Cares Support Wiltshire.
- The GP survey responses demonstrated that the practice was performing significantly better than the national average regarding GPs being good or very good at involving patients in decisions about their care.
- Following bereavement relatives were contacted and offered the opportunity of an appointment or a visit as appropriate. Care and support was person centred and tailored to meet the needs of an individual. The practice continued to invite bereaved carers to carer events at the surgery.

Privacy and dignity

The practice staff respected and were highly motivated to provide care that promoted patients' privacy and dignity.

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

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

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

Responding to and meeting people's needs

Services were tailored to meet the needs of patients and were delivered to ensure flexibility choice and continuity of care. The practice understood the needs of its population and tailored services in response to those needs.

- Telephone GP and nurse 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 made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example weekly or monthly blister packs, large print labels.

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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP also accommodated home visits for those who had difficulties getting to the practice.
- The practice recognised that the rurality of their practice population presented challenges for older people in accessing health care at the practice. In response to this the practice had collaborated with the community and part funded the community bus to provide transport for those who needed it.
- Flexible appointments were offered to those patients who needed a member of their family to transport them to the surgery.
- We spoke with manager of a nursing home that the practice delivered care for, who commented that the practice was responsive to the needs of the staff and patients. They had a GP contact at the practice who was very supportive ensuring that appropriate care was delivered in a timely manner. For example, the practice worked collaboratively with the nursing home and social services to support patients who had been admitted, to support an early discharge from hospital scheme.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients who attended the leg ulcer clinic benefitted from the social interactions that resulted from attending the clinic and quicker healing times. One patient had been receiving treatment for 12 months prior to the initiation of the leg clinic. The ulcer was healed within six weeks of attending the leg clinic.
- To ensure patients did not have to attend the surgery for multiple appointments integrated team appointments were offered where patients could consult with multiple clinicians and social support workers.

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.
- People's individual needs were central to planning tailored services. For example, ensuring the practice delivered an enhanced family planning service within the community people lived in, rather than having to travel into the nearest town.
- The practice had collaborated with local practices to initiate patients being able to visit any of the local practices to attend midwife appointments to provide greater flexibility of appointments for the benefit of patients.

Outstanding ☆

Are services responsive to people's needs?

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.
- The introduction of telephone triage and telephone consultations had improved access for working age people and the practice had received very positive feedback in the practices own patient survey.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- 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.
- Psychology practitioners held clinics at all the local practices and the practice had gained agreement from colleagues at other practices that patients could attend these appointments at the surgery of their choice.
- Young people's mental health had been identified as a target area within the localities. The practice provided emergency appointments and signposting for young people with mental health needs was available on the practice website. Patients were able to self-refer to the psychology practitioner.
- The practice hosted a dementia advisor one day each week where support was offered and patients signposted to additional services.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and that routine appointments were available within a few days.
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GP survey responses showed that the practice had performed significantly better than national average in areas relating to opening hours, getting through by telephone and experiences in making an appointment.

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 and as outstanding for providing a well-led service.

The leadership and culture of the practice was used to drive improvements and deliver high quality person centred care. The practice undertook a systematic approach to work effectively as a whole practice team, involve the patients and the community and other organisations to deliver the best outcomes and deliver the care within the community wherever possible. The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There was a clear leadership structure in place and staff felt supported by management. The practice had an experienced, stable team. They recognised that staff retention was integral to delivering a high-quality service and encouraged staff development in line with the needs of the individual, as well as the practice, and worked hard to ensure high staff satisfaction.

Vision and strategy

- The practice had a clear vision to ensure the highest standard of family care and to offer patients continuously improving and appropriate access to health care professionals.
- The practice valued staff engagement and the involvement and integration of the local community.
- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice culture promoted effective teamwork, where each team member was integral, in ensuring that high quality care was delivered to all their patients.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Staff members feedback was consistently positive about the support received from both the leadership team and their peers.
- The practice focused on the needs of patients and had adapted the way services were offered and delivered in order to enhance patient care and accessibility to the practice. For example having a volunteer driver programme for patient transport and training all staff in carer awareness
- 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. Staff provided examples of where they had raised suggestions with the leadership team and these had been actioned.
- 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.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.

Outstanding ☆

Are services well-led?

- 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. This was reflected in the positive comments received by patients about the staff at the practice and the high level of patient satisfaction in the national GP patient survey.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. For example, the utilisation of nursing home beds as an alternative to hospital admission where appropriate.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- 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. For example, improving appropriate antibiotic prescribing.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We looked at a number of these policies. For example, recruitment, chaperoning and infection control and found them to be in date and regularly reviewed.

Managing risks, issues and performance

There were clear and effective clarity around 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 sharing of significant events both internally and with the wider locality group maximised the opportunities to minimise future risk.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- A comprehensive understanding of the performance of the practice was maintained. The practice had used local and national data as well as in house data to identify areas where improvements could be made for the benefit of patients. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment which had led to improved outcomes for patients. For example, participation in the National Diabetes audit to adapt and improve the service delivered for patients with diabetes.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- We saw evidence in minutes of meetings that 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. For example, management of infection control.
- The practice used information technology systems to monitor and improve the quality of care. For example, monitoring the accuracy and efficiency of referrals when voice recognition software was introduced. The practice had identified that the time taken to process referral letters had improved since implementation of this software.
- The practice submitted data or notifications to external organisations as required.

Outstanding ☆

Are services well-led?

- There were 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.
- Educational events were set up on a quarterly basis to inform patients about health promotion.
- There was an active patient participation group. Meetings were attended by members of the leadership team. We heard of examples where suggestions from the PPG led to changes at the practice.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice held regular staff education sessions which were open to staff from other practices. These sessions had improved communications with secondary care and enhanced patient outcomes.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. For example, integrated team appointments for patients with complex health needs.
- The practice was an active training practice for medical and nursing students. The involvement of students was an important part in the practices vision and had supported recruitment and succession planning.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared internally and externally and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The leadership team had identified potential pressures on the management team to meet demands. As such the practice had employed additional staff with specific roles and responsibilities. This had resulted in improved performance in some clinical indicators such as annual health checks.

Please refer to the Evidence Tables for further information.