# Fremington Medical Centre

## Inspection report

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Date of inspection visit: 28 June 2018
Date of publication: 04/09/2018

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

## Ratings

| Overall rating for this location | Good |
|---|---|
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Overall summary

**This practice is rated as Good overall.** (Previous inspection October 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Fremington Medical Centre on 28 June 2018. The inspection was a routine inspection part of our inspection schedule.

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 processes.
- Patients gave strongly positive feedback at the inspection about staff treating them with compassion, kindness, dignity and respect.
- People's individual needs and preferences were central to the planning and delivery of flexible tailored services. All patient feedback highlighted ease of access to the appointment system, on the day assessment and short waiting time for routine appointments. Extended hours were available enabling working patients and school children to access a range of services from the multi-disciplinary team.
- IT was used effectively to engage patients in conversations about developments at the practice including social network sites. Access to advice and support was accessible for patients on the practice website.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Proactive succession planning based on staff development and training of future GPs, doctors and practice nurses was reinstated.
- Staff were committed to working collaboratively using innovative and efficient ways to deliver more joined-up care to vulnerable patients who used services.
- There were two areas where the provider could increase the frequency of audit to build on the quality improvement systems and review how patients who could be at risk of stroke or heart attack are assessed.

We saw areas of outstanding practice:

The practice established and ran a quarterly health and well-being club. Vulnerable patients who were not yet engaged with services were able to attend for companionship, healthy living advice and access support. Early identification of long term conditions, such as, hypertension (high blood pressure) had been picked up when blood pressure checks were done. At the June 2018 club, 13 patients had their blood pressure checked resulting in four booked in for review at the practice.

A dedicated internet application was developed at the practice for staff. This provided real time information easy access about current national guidelines, policies and procedures, shared learning, news, links and contact names and services available to signpost patients to.

An area where the provider **should** make improvements is:

Review the frequency of clinical audit to build on the quality improvement systems focussed on patient safety and effective care.

**Professor Steve Field** CBE FRCP FFPH FRCGPChief Inspector of General Practice

## Population group ratings

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

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and two practice nurse advisers (one of whom was on induction).

## Background to Fremington Medical Centre

The partnership of GPs registered as Fremington Medical Centre runs one registered location at the Fremington Medical Centre, which was inspected on 28 June 2018. This was a comprehensive inspection. The practice is located at:

Fremington Medical Centre

11-13 Beards Road

Fremington

Barnstaple

EX31 2PG

The practice provides a primary medical service to approximately 6900 patients of a diverse age group. The practice population is in the eighth deprivation decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. Particular areas of Barnstaple and the surrounding villages have higher levels of deprivation. There is a practice age distribution of male and female patient's equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 81 years and females to 84 years.

The partnership at the practice comprises of three GPs partners and an advanced nurse practitioner who is also a partner, they are supported by two part time salaried GPs Three of the GP partners are full time and one works part time at the practice. The team are supported by a practice manager, six practice nurses, five healthcare assistants and a full time clinical pharmacist. There are administrative and reception staff.

Fremington Medical Centre is an approved training practice providing vocational placements for GPs registrars. One GP partner is approved to provide vocational training for GPs, second and third year post qualification doctors. Teaching placements were due to commence for medical students and student nurses.

Patients using the practice also have access to community nurses, mental health teams and health visitors. Other health care professionals visit the practice on a regular basis.

The practice is open between 8am and 6:30pm Monday to Friday. GP appointments are available from 8.30 am. Early phlebotomy appointments are available between 8am and 8.30am for working patients. Extended hours opening is available every Monday Thursday from 6.30pm to 7.30pm. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments. Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Good

# Are services safe?

**We rated the practice as good for providing safe services.**

### Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We reviewed three files and found the practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure 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 were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role. This included an induction pack should any locum staff work at the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Assessment tools were seen displayed in all clinical areas and information in the waiting room for patients about early symptoms of 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 practice used a risk management system, which enabled patient records to be analysed to produce risk profiles to target audit activity, health screening and ongoing monitoring of patients. The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

### Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- 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.

### Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Good

# Are services safe?

- 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. An audit was undertaken on receipt of the safety alert in 2017 about the risks of sodium valproate (a medicine for epilepsy). This demonstrated the practice had identified all childbearing female patients who were prescribed sodium valproate, reviewed and altered the prescription where appropriate and advised them of the associated risks during pregnancy. A repeat audit had been carried out in 2018 again to ensure patients were appropriately followed up and changes made to their medicines where needed.

**Please refer to the Evidence Tables for further information.**

Good

# Are services effective?

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

**Effective needs assessment, care and treatment**

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had near patient blood testing for any patients on anti-clotting medicines (warfarin). This enabled patients to receive the result and guidance about dosing before leaving the practice.
- 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 regular clinical reviews including a review of medication. The practice had a monthly meeting to discuss all patients on the frailty register with the multidisciplinary team.
- 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.

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 and clinical pharmacist worked with other health and care professionals to deliver a coordinated package of care.
- Practice nurses were responsible for reviews of patients with long term conditions had received specific training. The nurses held diploma qualifications covering the management of patients with diabetes and respiratory conditions such as asthma and chronic pulmonary disease.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered 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 was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Standardised templates were used to assess patients to identify any risks, which prompted specific follow up actions.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages with some being exceeded. Performance was significantly above average for quality indicators covering respiratory conditions – asthma and chronic pulmonary disease.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%. Three out of four indicators were significantly above this target ranging from 96-98% for over 2s immunisations.
- 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 just below the 80% coverage target for the national screening programme. The practice uptake was above the local (76%) and national (72%) averages. Staff verified every contact with eligible women was used to encourage and support them to have cervical screening.
- The practice's uptake for breast and bowel cancer screening was above the national average.

Good

# Are services effective?

- 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 at least every five years. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice hosted a GP to carry out the IRIS (Identification and Referral to Improve Safety) role for Devon Public Health. Staff received training and support to facilitate early identification of victims of abuse and signposting to specific support services.

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. All patient or carer contacts from patients in crisis were treated as urgent and referred immediately to the GP.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages. The practice had acted on data from 2016/17 showing a higher exception rates for reviewing patients with dementia. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- The practice had utilised staffing resources and skills increasing the level of reviews carried out for patients living in care homes. The practice had created a substantive post for two days per week specifically for monitoring patients with frailty, complex and/or living in care homes. An elderly care specialist GP was due to take up post in October 2018.

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- Data for 2016/17 demonstrated the practice was achieving comparable results compared with local and national practices. However, performance rates for patient with long term respiratory conditions such as asthma and chronic pulmonary disease were above average. The practice shared the yet unpublished results for 2017/18 showing further improved performance with 100% of patients with respiratory conditions having been reviewed.
- We reviewed the outlier exception rate for patients with atrial fibrillation (a heart condition) receiving an anti-clotting medication. We found decisions to exception report patients were based on clinical rationale, for example a patient was undergoing treatment for cancer and inappropriate for them to attend for an appointment. Some patients chose not to attend, but were only excepted after three reminders, including contact from their named GP.
- The practice used information about care and treatment to make improvements. During the inspection, we found nursing staff did not complete a tool used nationally to determine whether a patient could be at risk of stroke or heart attack. We discussed this during feedback as area for improvement.

Good

# Are services effective?

- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

**Effective staffing**

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. The practice management team had oversight of all mandatory and specific training via an online system and were able to demonstrate staff had updated or were due to later in the year.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The practice had a competency framework, which staff were familiar with setting out values and behaviours expected of them.

**Coordinating care and treatment**

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

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

**Helping patients to live healthier lives**

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- 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.**

Good

# Are services caring?

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line or above local and national averages for questions relating to kindness, respect and compassion. Some indicators were significantly positive.

**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 patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were in line local and national averages for questions relating to involvement in decisions about care and treatment. The percentage of respondents to the GP patient survey who answered positively about whether they had confidence in their GP was 100%, which was above the local and national averages.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

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

**Please refer to the evidence tables for further information.**

Good

# Are services responsive to people's needs?

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

**Responding to and meeting people's needs**

- The practice organised and delivered services to meet patients' needs. The practice had 6896 patients, with below average percentage of young patients. Over 33% of patients were over 65, which is over twice the national average. It took account of patient needs and preferences.
- The practice understood the needs of its population and tailored services in response to those needs. The practice set up a well-being club for the community in 2017 to reduce isolation and establish early identification of any risks for patients who were not yet frail but could be vulnerable due to other circumstances.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice used 'E–Consult' giving patient access to GP advice via a secure login and web form. Repeat prescriptions could be ordered on line and most were sent electronically to the patient choice of pharmacy.
- 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 are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Patients were able to access appointments with two GPs for minor surgical procedures, including the removal of uncomplicated skin lesions.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Nurse Practitioners provided appointments for patients with minor illnesses, minor injuries and family planning.
- Acupuncture was available to all patients who were suitable for an alternative treatment approach to relieve musculo-skeletal issues.

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, clinical pharmacist and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to frailty or limited access to transport.
- Arrangements were in place with local pharmacies to provide a delivery service of medicines prescribed for housebound patients.

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.

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.
- The practice had a well-established recall system with named staff monitoring the childhood immunisation register. On receipt of the hospital discharge letter the practice sent out a congratulations card and an appointment for the baby and parent/s to see the GP and practice nurses. Staff told us they saw this as an important opportunity to engage with parents to explain childhood health, support available and services at the practice.

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.

Good

# Are services responsive to people's needs?

People whose circumstances make them vulnerable:

- Systems were in place for early identification and support of suspected victims of abuse.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patient records included details about specific needs such as accessible information requirements.
- 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.
- Patients in mental health crisis were dealt with as a medical emergency and flagged as urgent to their named or duty GP.
- Named clinical staff were linked to care homes, carrying out regular visits each week to do medicines and frailty reviews.
- The practice had staff who were skilled mental health and dementia practitioners. All staff were 'Dementia Friends' and able to identify if a patient needed assessment or support. Patients who failed to attend were proactively followed up by a phone call from staff who knew them.
- The practice sign posted patients to the local depression and anxiety service.
- Private counselling and hypnotherapy was hosted at the practice.

**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.
- The practices GP patient survey results were in line with or above local and national averages for questions relating to access to care and treatment. Responses from patients about being able to get an appointment with a GP or nurse when they wanted to were significantly positive (practice 93%, local 85% and national 75%).

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded 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.**

Good

# Are services well-led?

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

### Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them in line with the practice business strategy. For example, in recognition of national and local challenges recruiting GPs the practice reviewed the skill mix and diversified roles. It had recruited an advanced nurse practitioner, nurse prescribers, and a clinical pharmacist for the practice since the last inspection in 2014.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

### Vision and strategy

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

- There was a clear vision and set of values. These were to provide quality patient care based on: respecting others, working as a team, embracing change, being an effective business, having effective leadership and patient focussed. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy and had an annual away day to plan ahead each year.

### Culture

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

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

### Governance arrangements

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

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

### Managing risks, issues and performance

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

Good

# Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient and staff safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

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

**Engagement with patients, the public, staff and external partners**

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. A GP partner had been on the Devon Doctors' board since 1996 and on the board of Devon Local Medical Committee.
- There was an active patient participation group, with early consultations and involvement in plans to refurbish and extend the building as well as development of community focussed services such as a health and well-being club.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. For example, the practice manager represents the practice at the North Devon practice manager meetings and also an alliance meeting with other Barnstaple practices.

**Please refer to the evidence tables for further information.**