Priory Road Medical Centre

Inspection report

Priory Road
Park South
Swindon
Wiltshire
SN3 2EZ
Tel: 01793 688744

Date of inspection visit: 8 June to 8 June
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

This practice is rated as Good overall. (Previous inspection 14 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 Priory Road Medical Centre on 8 June 2018, as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice developed a protocol for dealing with male hypogonadism and testosterone replacement, that was consistent with the British Endocrine Society.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality.
- Priory Road Medical Centre identified patients at risk of developing diabetes who were not on the diabetes register, and implemented changes that could help to prevent the progression of this health condition.
- Patients were offered a range of services to help them improve and manage their health condition. These included a test to determine how well their lungs were performing, and retinal and blood glucose screening.

The areas where the provider **should** make improvements are:

- The provider should continue to make efforts to increase the programme coverage of women eligible to be screened for cervical cancer.

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, and included a GP specialist adviser.

Background to Priory Road Medical Centre

The provider, Priory Road Medical Centre, delivers all regulated activities from its sole location at:

Priory Road Medical Centre

Priory Road

Park South

Swindon

SN3 2EZ

Tel: 01793 688744

Website: www.prioryroadmedicalcentre.org.uk

Priory Road Medical Centre is located in Swindon, Wiltshire, and is one of 25 practices serving the NHS Swindon Clinical Commissioning Group (CCG) area. The practice has occupied its current, purpose-built premises since 2005, and is arranged over two floors. All patient services including nurse treatment and GP consulting rooms are located on the ground floor.

The practice has around 8,600 registered patients from an area surrounding the practice and Swindon town centre. The practice age distribution is broadly in line with the national average, with most patients being of working age or older. Priory Road Medical Centre has started the process of merging with six other NHS GP practices locally, to become the Wyvern Health Partnership. The aim of the merger is to develop services, share best practice and collaborate on health initiatives.

Priory Road Medical Centre is a training and teaching facility for clinical staff, and accommodates three to four, fourth year medical students each on a four-week placement.

The practice has a Personal Medical Services (PMS) contract to deliver health care services. PMS contracts are locally-agreed alternatives to the standard General Medical Services contract, and used when services are agreed locally with a practice. They may include additional services beyond the standard contract.

Priory Road Medical Centre provides the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures

There are three GP partners (one female, two male), and three salaried GPs (one male, two female). The wider clinical team consists of three nurses and one Health Care Assistant (HCA). A clinical pharmacist, employed by the local clinical commissioning group (CCG), is based at the

practice one day per week. The practice manager and assistant practice manager are concerned with the day-to-day running of the practice. Three staff members combine their work as phlebotomists with administrative, secretarial and reception duties.

87% of the practice population describes itself as white, and around 13% as having a Black, Asian and Minority Ethnic (BAME) background. A measure of deprivation in the local area recorded a score of 3, on a scale of 1-10. A higher score indicates a less deprived area. (Note that the circumstances and lifestyles of the people living in an area affect its deprivation score. Not everyone living in a deprived area is deprived and not all deprived people live in deprived areas).

Priory Road Medical Centre is open from 8am to 6.30pm, Monday to Friday, and is also open one Saturday per month. The practice will take calls during these times (except on Saturday mornings). Routine GP appointments are generally available from 8.30am to 11.30am and 3pm to 6pm, Monday to Friday. The practice provides (pre-booked only) extended hours morning appointments from 7.30 am to 8am on Wednesday, Thursday and Friday, with a GP and nurse.

The practice has opted out of providing Out-Of-Hours services to its own patients. Outside of normal practice hours, patients can access the NHS 111 service, and an Out-Of-Hours GP is available at Swindon Walk-In Centre. Information about the Out-Of-Hours service was available on the practice website, on the front door, in the patient registration pack, and as an answerphone message.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure 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.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- 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.
- There were effective protocols for verifying the identity of patients during remote or online consultations.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The practice discussed its high (relative to local and national averages) prescribing of hypnotics that are age and sex related (These are referred to as Specific Therapeutic group Age-sex Related Prescribing Units, or STAR PU. By adjusting for age and sex, as well as the total numbers of patients, the units allow for more accurate comparisons between practices in their prescribing rates. Please refer to the **Evidence Tables** for further information). We spoke to the practice and they told us they were aware of the issue. We saw more

Good

Are services safe?

recent, unverified data which showed their prescribing rates for the last quarter were more comparable with local and national averages. We also saw documentary evidence that hypnotics prescribing had been discussed at a recent clinical meeting.

Track record on safety

The practice had a good track record on safety.

- 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

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

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 computer systems enabled them to check patients' treatments against best practice guidance, to improve their health outcomes and to monitor performance against the QOF. For example, the practice ran a quarterly computer audit of all patients prescribed an anticoagulant medicine (medicines used to prevent the risk of blood clots) to check they had had the regular blood test recommended for these medicines and that the results were within the therapeutic range. The results were seen by clinicians who were able to take action, such as contacting the patients and asking them to make an appointment to be seen, where appropriate.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured 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.
- Patients could access a community navigator, employed by Swindon Borough Council. The community navigator supported patients to become more independent and use community services to prevent isolation and mental health issues. Patients were alerted to the navigator through the patient information leaflet and through a GP.

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.
- 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 was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were higher than the target percentage of 90%, apart from children aged two who had received their immunisation for Haemophilus influenza type b and Meningitis C, which was slightly below the 90% minimum target. When we spoke to the

practice, they outlined a series of measures to address this. These included a message to patients to increase awareness and uptake of the vaccine, and practice staff attendance at a forthcoming workshop on improving childhood immunisation rates in Swindon.
- 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, based on data from 2016-2017, was 70%, which was below the 80% coverage target for the national screening programme. The practice was aware of this, and had taken action to improve screening rates. The practice provided data (not externally verified) to evidence the improvements. Measures taken by the practice included:
  - Ensuring all sample-takers had received initial training, including updating every three years.
  - Ensuring all sample-takers monitored results from the samples they took, including their rate of inadequate samples. If this was above 5% the sample taker initiated an investigation.
  - Ensuring patients were offered appointments at different times throughout the week, including late appointments, and a female sample-taker was available.
  - Ensuring patients received a written invitation, and at least one written reminder, by the local screening office. A third reminder, in the form of a telephone call, was sent to patients who failed to attend.
- The practice uptake for bowel cancer screening was slightly below local and national averages. When we spoke to the practice, they told us they now send personalised bowel screening letters directly to patients, to improve uptake.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients diagnosed with acute issues could be offered faster clinic appointments at SUCCESS centres. SUCCESS (Swindon Urgent Care Centre and Expedited Surgery Scheme) centres are clinics based at two other local NHS practices and operated by a company named Medvivo, on behalf of NHS Swindon CCG.

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 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.
- 81% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those

living with dementia. For example, 90% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- 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.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity, which included conducting clinical audits, and routinely reviewing the effectiveness and appropriateness of the care provided. For example, we reviewed one completed cycle of a clinical audit where the practice had identified and implemented improvements. The audit sought to identify patients on the asthma register with a high (12 or more prescriptions per year) usage of a medication that opens up the medium and large airways in the lungs. High usage of this medication has been associated with a range of health issues such as headaches, coughs and heart palpitations. The audit was conducted in June 2017 and found that 52 patients collected 12 or more prescriptions for inhalers. Of these, 19 were receiving specialist care, eight were collecting regular repeat prescriptions despite well-controlled asthma and infrequent symptoms; and 14 were using inhalers regularly, without attending clinical reviews. The eight patients with infrequent symptoms were sent a letter informing them that their repeat medications were being reduced, and offering them an appointment to discuss further; and the 14 patients who had not attended for clinic reviews were sent a letter informing them of the adverse health effects of high usage of inhalers, and advising them to make an appointment with the asthma nurse. A re-audit in May 2018 found that 34 patients had reduced their usage of inhalers. The practice plans to undertake a third audit in the near future and will continue to target patients with high usage on the register.

Effective staffing

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

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

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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.

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.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice 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.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.
- The practice provided dedicated GP contact for two nursing homes. Ward rounds took place weekly, and formal medication reviews six-monthly.
- Patients could access a range of facilities to ease comfort and facilitate navigation. These included raised armchairs in the waiting area, support frames in the consulting rooms, and contrasting colours on the woodwork.
- Wound and ulcer appointments were booked directly with nurses to ensure ongoing management.

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.
- Diabetic patients were provided with a diabetic passport, which helped them take an active role in their treatment with insulin.
- The practice had developed a protocol for dealing with male hypogonadism and testosterone replacement, that was consistent with the British Endocrine Society.
- The practice offered diabetic health checks to promote self-management and individualised care planning.
- Patients could have a spirometry and reversibility test to determine how well their lungs were performing.
- The practice offered retinal screening.
- The practice held an obesity register to ensure this patients had their needs met and offered blood glucose screening.
- The practice offered medicines reviews with a clinical pharmacist.
- Patients were referred to a range of health management and prevention programs such as weight management and managing COPD.

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 offered a range of birth control services. These included same-day emergency contraception, psychological counselling, and coil fitting and removal.
- Younger children could access emergency appointments after 5pm, Monday to Friday. There were suitable safeguards and protocols in place.

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, text reminders for appointments, telephone consultations and online booking of appointments.
- The practice offered screening services for abdominal aortic aneurysms.
- The practice offered a range of additional, non-contracted services in response to patient need. These included nasal cautery, ear irrigation and western-style acupuncture.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, and nursing home residents.
- The practice hosted weekly drop-in sessions for victims of domestic violence.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated weekly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients were offered a range of services to help them improve and manage their mental health issues. For example:
  - The practice hosted a talking therapy service. The service was funded by the local clinical commissioning (CCG) and was available on referral three days per week. Patients could also self-refer to the service.
  - A practice GP offered neurolinguistic therapy (NLP) for treatment of conditions such as anxiety and phobias. NLP seeks to educate people in self-awareness and effective communication, and to model and change their patterns of mental and emotional behaviour.

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.

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. For example, a patient arrived at the practice and attempted to use the booking-in screen to confirm his appointment. He believed this to be faulty and decided to sit in the waiting room, without informing reception staff. By the time staff were aware of the patient, the nurse who was due to treat him was already involved with another patient. After waiting some further time, the patient decided to access another local service for treatment. The practice discussed the issue and the practice manager contacted the patient to apologise. It was explained that reception staff should be notified if the screen is faulty; and the practice added a notice to the touch screen, requesting that patients speak to reception if experiencing problems.

Please refer to the Evidence Tables for further information.

Are services well-led?

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

Leadership capacity and capability

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

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

Vision and strategy

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

- There was a clear vision and set of values. The practice 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 had a culture of high-quality sustainable care.

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

Governance arrangements

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

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

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical

staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on and had appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

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

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