Frome Valley Medical Centre

Inspection report

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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 rating April 2015 – Outstanding)

We found that although some of the previous outstanding elements had been retained within the practice further development of these initiatives had not been implemented since our previous inspection.

The key questions at this inspection 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 Frome Valley Medical Centre on 7 August 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 focus on and improvement at all levels of the organisation.
- The practice had a very active patient participation group who were responsible for initiated some innovative projects such as the Combatting Loneliness and Isolation Project to identify community links and resources which could provide social contact and support for patients.

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

- Review document management to ensure that all recruitment documentation is held in one place.
- Review the protocol for exception reporting so that the decision making process is clear.
- Risk assess the emergency medicines which were not held by the practice.
- Review processes to establish a programme of clinical review of the effectiveness and appropriateness of the care provided.

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

Please refer to the detailed report and the evidence tables for further information.

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 Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

Background to Frome Valley Medical Centre

Frome Valley Medical Centre

2 Court Road

Frampton Cotterell

Bristol

BS36 2DE

Frome Valley Medical Centre provides primary medical services to approximately 14,500 patients living in Frampton Cotterell and surrounding villages in South Gloucestershire on the north eastern outskirts of Bristol. The practice has a pharmacy and some complimentary health services within the building. The practice provides primary care to four residential homes and one nursing home as well as a residential site for the traveling community.

The South West UK Census data (2011) shows 3% of the population are recorded as being from the black or minority ethnic community. Public Health England's national general practice profile shows the practice has a significantly lower population of patients aged between 20 and 39 years old and a higher than England average group of patients aged 75 or over (11.8%). This has resulted in a higher that England average number of consultations per patients over 65 years old at 17.8 per year.

The practice population has low levels of deprivation. The Index of Multiple Deprivation 2015 is

the official measure of relative deprivation for England. The practice population is ranked at decile 10 which is the lowest level of deprivation.

The surgery was purpose built and is owned by the GP partners. The building is set over two floors with patient access to the first floor by lift. It has an access ramp to the entrance of the building and a large car park with blue badge reserved parking. There is a separate reception area with an automated arrival system and spacious waiting room.

The practice team includes five GP partners and five salaried GP's; a strategic manager and deputy operations manager; a nurse manager; three advanced nurse practitioners, five practice nurses; three healthcare assistants; a pharmacist; a phlebotomist and administration staff.

The practice is an accredited training practice for GP trainees, foundation year trainees and medical students.

The practice has a Primary Medical Services contract (PMS) with NHS England to deliver general medical services.

The practice has opted out of providing out-of-hours services to their own patients. Patients can access NHS 111 and out of hours services from information on the practice website.

The practice is registered to provide the following regulated activities:

Family planning

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Surgical procedures

Maternity and midwifery services.

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. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice had a system for carrying out appropriate staff checks at the time of recruitment; however, the documentation in respect of references was not available in all the staff files we reviewed.
- 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. We noted that the practice did not hold all the emergency medicines recommended and had not risk assessed the reason for not holding the medicines.
- 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.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. They were part of the NHS England locality information sharing system called Connecting Care. This allowed approved health care professionals such as the Out of Hours GP service to be able to access patient records. This meant that diagnosis and treatment decisions were supported by the information in the patient medical record.
- 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, and equipment, minimised risks. A risk assessment for the emergency medicines recommended but not held was not in place.
- 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. For example, in line with national guidance they reviewed all patients in receipt of antibiotic prophylaxis prescriptions to ensure they were used according to national guidelines.
- 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 had identified that some reviews were overdue

and had assessed and planned a course of action to address this by employing a permanent practice pharmacist and establishing a medicines management team.

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 safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had accessible equipment in the waiting room for patients to be able to self-monitor their weight and blood pressure, and had purchased equipment for the diagnosis of atrial fibrillation.
- 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 comprehensive geriatric assessment using a national toolkit to assess health and wellbeing. It included 40 minutes with a health care assistant where wellbeing issues were discussed followed by a 20 minute GP appointment which included a review of medicines. The practice had a 100% achievement for reviewing medicines for frail patients in the last 12 months which had impacted on the number of emergency admissions of patients which was less that the local average for 2017 and reduced usage of out of hours services.
- 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 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.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected high blood pressure 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).
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% or above. Information on childhood immunisation coverage at ages one, two and five are collected through the NHS England child immunisation practice level collection for 2016/17, and indicated the practice was achieving higher levels than the World Health Organisation (WHO) standard for 95% of children to receive recommended vaccinations.
- 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 81.2%, which was above the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was above 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.

Good

Are services effective?

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The practice monitored the uptake of these health checks and ensured 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 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.

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 medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice staff were part of the Dementia Friends Scheme and had completed additional awareness training to support people living with dementia.
- The practice offered annual health checks to patients with a learning disability.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) was 100% which was better than local (91%) or national (91%) averages.

Monitoring care and treatment

The practice had undertaken quality improvement activity in response to external risks such as medicine reviews, and internal reviews in response to performance such as the Quality and Outcomes framework (QOF) performance for diabetes indicators. (QOF is a voluntary reward and incentive programme. It rewards GP practices, in England for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care). There was no established programme of clinical review of the effectiveness and appropriateness of the care provided; however, where appropriate, clinicians took part in local and national improvement initiatives such as a review of usage of prophylactic antibiotics.

- The practice achievement for the QOF was 100% for 2016/17. The overall exception rate for the practice was similar to the local average which was higher than the national average. The exception rates for the indicators for mental health, diabetes, osteoporosis was higher than the local or national averages. We looked at a random sample of notes for three patient exceptions reported for diabetes, however there was no explanation by free text entry in the excepted patients notes (other than the exception code) why they were excepted.
- The practice used information about care and treatment to make improvements. For example, the audit of patients in February 2018 with diabetes found 32% with a blood pressure measurement higher than the recommended guidelines. These patients were requested to attend for further checks and wherever necessary appropriate treatment prescribed. The impact for these patients was that 81% of patient's blood pressure readings had decreased to within acceptable limits, and there was greater awareness amongst the clinical team for closer observation and control for hypertension with diabetics.

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.

Good

Are services effective?

- 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. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. All GPs new to the practice or retuning to work after a period of absence were assigned a mentor. Where staff had extended roles such as one health care assistant and the advanced nurse practitioners there was a robust system of ongoing support and review.
- 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 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.
- The practice convened a weekly multidisciplinary team, which included a virtual ward round, at which any voluntary agencies providing support were invited to attend. The practice provided an administrator to co-ordinate the meeting and produce minutes which were circulated among attendees where appropriate for action.
- 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. End of life and palliative care patients were discussed at the weekly meetings. The practice used the electronic palliative care co-ordination system (EPACCS) to share information.

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 the practice hosted a community connector who could signpost patients through to well-being 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 practices GP patient survey results (July 2017) were in line with or above local and national averages for questions relating to kindness, respect and compassion.
- The practice worked closely with local voluntary groups; Age UK who provided foot care clinics accessible by all the local community and not restricted to the practice patient group, and the Carers Trust who ran monthly carers clinics at the practice.
- The practice was awarded the GP Gold Standard for Carers from the Carers Trust assessment for ensuring services which identified and supported carers were in place at there.
- The patient participation group were actively initiating innovative projects which impacted on patients such as the their current Combat Loneliness and Isolation Project (CLIP).
- The staff and patients were involved in charitable work which directly supported patients such as the Friends of Frome Valley who fund raise for additional equipment, and support the air ambulance charity.

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 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 and the patient participation group had initiated a survey at the practice to identify carers which resulted in an increase by 20%.
- The practices GP patient survey results (July 2017) were in line with local and national averages for questions relating to involvement in decisions about care and treatment.
- The GPs met with relatives at the care homes to discuss ongoing care and any advanced care decisions.

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. 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 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. The prescription coordinator supported patients discharged from hospital to access follow up services both within and outside the practice.
- The practice used an electronic scoring system to identify patients at high risk of admission and ensured care plans were in place. They could access the Age UK well-being scheme for patients who have experienced unplanned admissions and may have long term conditions.
- 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.
- The practice planned additional appointments and time for home visits in the winter months for older patients.
- They used the Comprehensive Geriatric Assessment (CGA) for older patients which had been shown to result in better care for 60% of patients within the clinical commissioning group area.
- They provided GP ward rounds to six care homes with attendance from a regular GP. The impact had been a significant decrease in the number of hospital admissions and emergency department attendances.
- The practice provided training for care home staff for example, with on-line ordering of care home residents' medicines which had resulted in safer, timelier provision of medicines.
- The practice offered seasonal immunisations at the weekend and late appointments during the week, so that older patients could use family and carers for transport.
- They provided immunisation at home when needed for the 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.
- Specialist practice nurses visited housebound patients to monitor chronic diseases and perform frailty assessments.
- The practice screened for new long term conditions, for example, opportunistic checking of pulse for atrial fibrillation at long term condition annual reviews.
- The practice undertook NHS health checks and had identified a large number of patients with prediabetes over the last 5 years (746) who had been able to be treated according to need.
- The practice had been involved in several long term conditions projects. For example, a diabetes care pilot

scheme to identify, refer and discuss patients with poorly controlled diabetes with a diabetes nurse specialist which allowed for the healthcare staff involved to develop their skills.

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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- There were phlebotomy services available for children.
- The practice had nurses specially trained in sexual health and family planning.
- The practice used local mental health referral systems such as Off The Record for younger people and hosted counsellors.
- The practice participation group had undertaken a survey for new parents to identify them and work toward establishing a specific support social group at the practice.
- The practice was part of the local minor injury scheme and offered daily bookable appointments with specially trained staff.

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 practice participated in the direct access to musculoskeletal physiotherapy project which provided quicker access for treatment of acute conditions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- There was a community of travellers who used the practice. There were measures in place to facilitate these vulnerable groups accessing services such as on the day urgent appointments for routine problems; phone contact rather than letters and requesting secondary care to phone them for outpatient appointments.
- One GP with special interest provided a weekly visit to two care homes for people with learning disabilities; these patients have an annual face to face review.
- 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):

- The practice offered the same clinician for mental health patients and visited patients at home if they felt unable to attend.
- The patient participation group worked with a group of young people to upgrade information relating to mental health on the practice website.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was involved in a pilot to increase the rate of diagnosis of dementia and support provided. GPs were trained to diagnose, treat, support, signpost, manage and follow-up routine diagnoses of dementia in patients over 75 years. This pilot had been successful and was adopted across the local area.

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.

Good

Are services responsive to people's needs?

- The practices GP patient survey results (July 2017) were in line or above local and national averages for questions relating to access to care and treatment.

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 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.
- 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.
- 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.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. The practice had surveyed their staff and taken action in response to the comments received.
- 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.
- 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, with regular team days and social activities held to promote good relationships.

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
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However some of the processes were such as clinical review and exception reporting need to be refine and embedded by the practice

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

Good

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was 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. For example, we found they had a list of key performance indicators which were monitored on a weekly basis and resources planned and adjusted to ensure performance targets were met.
- The practice used information technology systems to monitor and improve the quality of care. The practice had noted that their disease prevalence registers did not fully reflect the work of the practice and had arranged for a software data collection and analysis tool to scan the patient records. This identified patients within a number of disease areas who should be on the disease register because they have had the relevant interventions and ensured patients had appropriate treatment.
- 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 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.

Please refer to the evidence tables for further information.