Tavyside Health Centre

Inspection report

Abbey Rise
Tavistock
Devon
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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 – 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 Tavyside Health Centre on 13 and 18 June 2018. The inspection was a routine inspection as part of our inspection schedule carried out over two days. We visited the main site and branch surgery at Lifton, which had a dispensary.

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.
- Staff were caring and patient focussed.
- 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 minor injuries services. Extended hours were available every day enabling working patients and school children to access a range of services from the multi-disciplinary team.
- As a training practice, 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 evident.
- Tavyside Health Centre had successfully registered additional patients in 2016/17 when the practice merged with Lifton Surgery. Patient feedback shared with us by patient representatives at Lifton Surgery was positive about the changes being made there.

We saw an area of outstanding practice including:

The practice had extended their tailored learning disability service, which had increased to 35 patients within this population group. A lead GP and senior health care assistant did domiciliary visits to patients at their own home. Staff used advanced total communication skills such as makaton signing and easy read letters with patients so they were fully involved in their health assessment and care planning.

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

Review the infection control processes to include hand hygiene audits to identify competency issues and training gaps for staff.

Review the prescription authorisation process to ensure changes implemented are embedded 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 a CQC pharmacist inspector.

Background to Tavyside Health Centre

The partnership of GPs registered as Tavyside Health Centre runs one registered location in Tavistock and a branch surgery in Lifton. This was a comprehensive inspection over two days covering both sites, including the dispensary located at Lifton Surgery.

The practice is located at:

Tavyside Health Centre, Abbey Rise, Tavistock, Devon PL19 9FD

The branch surgery is located at:

Lifton Surgery, North Rd, Lifton, Devon PL16 0EH

The practice provides a primary medical service to 12,354 patients of a diverse age group. The practice population area is in the seventh deprivation decile. In a score of one to ten the lower the decile the more deprived an area is. The surrounding villages have higher levels of rural 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 80 years and females to 85 years.

There is a team of eight GPs partners, supported by four salaried GPs (five male and seven female). The team are supported by a practice manager, four practice nurses, four healthcare assistants and a part time clinical pharmacist. There are dispensing staff at Lifton Surgery and administrative and reception staff on both sites.

Tavyside Health Centre is an approved training practice providing vocational placements for GPs registrars. Four GP partners are approved to provide vocational training for GPs, second year post qualification doctors and medical students. A GP registrar was on placement when we inspected. Teaching placements are provided for medical students, post qualification doctors, student nurses and paramedics. 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. Appointments are available from 8am every morning and 6pm daily. Extended hours opening is available on a Thursday from 7.30am to 8.30am and alternate Saturday's from 8am to 12pm.

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 in line with local arrangements.

The practice is able to offer dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy in the surrounding areas near to Lifton Surgery. The dispensary is open for ordering and collection of medicines from 8am to 12pm and from 2pm to 6pm. Patients are also able to collect medicines from reception during opening hours.

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 for newly recruited staff 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 for locum staff and students working at the practice. Medical students were provided with a basket containing a current copy of the British National Formulary, calibrated medical equipment and information about the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice had reduced risks with staff working across two sites at Tavistock and Lifton by having the same contents and emergency equipment in a location known to staff.
- 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 for staff to follow if a patient presented with infection. Reception staff had an escalation pathway outlining when to request urgent input from the duty GP to assess a patient to prevent 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 had upgraded the patient record system so patient records could be accessed at both sites. 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 when data showed it was an outlier. Actions taken had reduced antibiotic prescribing in 2017/18 supporting good antimicrobial stewardship in line with local and national guidance.

Good

Are services safe?

- 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.
- 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. For example, an audit was undertaken on receipt of the safety alert about the risks of sodium valproate. This demonstrated the practice had identified all female patients who were prescribed sodium valproate, reviewed and altered the prescription where appropriate and advised them of the associated risks during pregnancy.

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.
- Staff used easy read and picture prompt cards to support patients' independence and involvement, for example when preparing patients with learning disabilities for well woman/man health checks.
- Staff used appropriate tools to assess the level of pain in patients. Templates seen on the computer system prompted staff to record baseline information.
- 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 were referred to the community matron for proactive care management.
- 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.

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 above the target percentage of 90%, for example the practice rates for children under one was 97.9% and over twos 95.5% to 96.5%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 76%, which was below the 80% coverage target for the

national screening programme. (Uptake rates locally were 76% and 72 % nationally). Staff verified every contact with eligible women was used to encourage and support them to have cervical screening.
- The practices' uptake for breast and bowel cancer screening was above the national average. The practice had screened 84% of eligible females for breast cancer (local 67% and national 62%
- 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.

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.

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.
- 72% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the national average.
- 99% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 99% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above 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 to the local memory clinic in Plymouth.
- The practice offered annual health checks to patients with a learning disability and had achieved 100% in completing these

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. Scheduled audits of clinical and non-clinical areas were agreed and completed over the course of every year.

- The practice used information about care and treatment to make improvements. An audit reviewed exception reporting at the practice for 2016/17, which led to changes being made to the way long term conditions were coded. 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 was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives such as the setting up of a Primary Care home with other local practices and professionals. A primary care home is an innovative approach to strengthening and redesigning primary care. The model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for people living in and around Tavistock.

Effective staffing

Good

Are services effective?

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. A practice based pharmacist was jointly funded with the clinical commissioning group and the practice, and was carrying out regular medicine 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. There was a low turnover at the practice. The ongoing training for healthcare assistants was comprehensive. The practice was aware of 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 through the staff development system of appraisal.

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. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in 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. Patient records sampled, demonstrated appropriate documentation of discussion with the patient about any benefits and risks of treatment options and or consent for procedures.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services effective?

- The practice monitored the process for seeking consent appropriately by undertaking an annual audit.

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 18 patients, verbally and in comment cards was mostly 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 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

Services were tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. It took account of patient needs and preferences.

- Patients were actively involved in the development of services through the patient representative group and virtual group.
- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations, appointments early in the day and on alternate Saturday mornings 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.
- The national GP survey results for 2017 were positive in regard to accessing appointments, opening hours and overall experience.

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.

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.
- Near patient testing for conditions requiring regular blood monitoring were available. Patients were able to receive immediate blood results and have their medicines dosages changed accordingly before leaving the practice.

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.
- After and before school routine appointments were available, avoiding any disruption to the school day.
- The practice had appointments set aside for students from a local Independent school and ran clinics, such as an asthma clinic, at the school. Some students at this school were on the Olympic swimming training programme requiring extensive fitness checks by the practice.
- Parents were able to access longer appointments for their baby to be checked and have their first immunisations. At these appointments staff explained the immunisation schedule and arranged future appointments with the parent/s. This had an impact on update rates, which were significantly above the national target of 90% ranging between 95% and 98%.

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 every Thursday and alternative Saturday mornings.
- Patients were able to sign up for online access to their records, request medication and appointments.
- NHS health checks were offered including cholesterol testing.
- Travel clinic services, including yellow fever were available by appointment, including during extended hours, with nursing staff.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had extended the long established tailored service, which had increased to 35 patients with learning disabilities. A lead GP and senior health care assistant did domiciliary visits to patients at their own home. Staff used advanced total communication skills such as makaton signing and easy read letters with patients so they were fully involved in their health assessment and care planning.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. Systems were in place to facilitate communication between secondary care and people with no fixed abode, whereby the practice acted as a point of contact.

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.
- GP regularly reviewed all patients with mental health and dementia. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice hosted talking therapy appointments via the local depression and anxiety service.

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.
- 18 patients verbally and in comment cards 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.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups 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. For example, the overall practice list had increased by over 3,000 patients following the merger with Lifton Surgery and was well managed. The practice had planned for future population growth in the area to avoid impact on services.
- 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 in an education focussed practice.
- 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 organised regular social events for team building.
- 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 was supported to meet the requirements of professional revalidation where necessary.
- Clinical staff was 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. We saw several examples, including: standing items at the partners meeting monitored patient health review performance (Quality outcome framework - QOF). Equity and safety management of GP patient list size. 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

Good

Are services well-led?

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 appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Recent audits determined whether exception reporting of any patient reviews was based on clinical assessment. 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. For 2016/17 the practice had achieved an overall quality outcome framework (QOF) score of 100% for reviewing patients.
- 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 representation group as well as a virtual group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement as a training practice. For example, staff were supported to develop in house. Some staff had moved from administrative, to middle management or administrative to clinical roles.
- 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.