Exmoor 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?	Outstanding
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous rating November 2014 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Exmoor Medical Centre on 19 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. The systems such as the cancer significant event audit and the range of multi-disciplinary meetings led to improved, consistent high-quality care. 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 could access care when they needed it.
- The practice undertook additional patient surveys such as individual GP feedback and bereaved family's surveys following end of life care. They used colleague feedback surveys. These along with the national GP patient survey (2017) showed above average positive patient feedback.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

The practice had received accreditation for high quality end of life care and implementation of the Gold Standard Framework (GSF). The practice demonstrated innovative best practice and improvements in local care standards through implementation of the GSF for all patients with cancer and additional patient population groups. As a result, they could demonstrate improvements in quality of care provided.

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

- Review the security of blank prescriptions within clinical rooms so that it is in line with national guidance.

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	Outstanding
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Outstanding
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 member of the CQC medicines team.

Background to Exmoor Medical Centre

Exmoor Medical centre is in Dulverton, Somerset within Exmoor National Park. It offers a dispensing service for patients who live more than one mile (1.6 kilometres) from their nearest pharmacy. The practice has a General Medical Services (GMS) contract to deliver primary health care to the local population.

The service operates from a purpose-built building which is co-located with a dental surgery: Oldberry House, Fishers Mead, Dulverton, Somerset, TA22 9EN. We visited this address as part of our inspection. Further information about the practice can be found at www.exmoormedicalcentre.co.uk

The practice serves a population of approximately 4,000 patients over a rural area of 300 square miles which encompasses Devon and Somerset, which brings its own challenges of divided healthcare services over two counties. The Index of Multiple Deprivation 2015 is the official measure of relative deprivation for small areas in England. The deprivation decile for this area is five with one being the least deprived and 10 the most. The practice had a higher than average number of patients aged over 65 which equates to 32% of the practice population compared with the local average of 24% and national of 17%. The percentage of patients aged over 75 was 14% compared to 10% (local) and 7% (national).

The Partnership is registered with the CQC in respect of the regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures and Treatment of disease, disorder or injury.

The practice partnership consists of two GPs and the practice manager. In addition, a salaried GP is employed which equates to the provision of 19 GP sessions per week in total. The practice team includes two registered nurses, a practice manager, a health care assistant, deputy practice manager, administrative and dispensary staff.

The practice is a training practice for trainee GPs. At the time of the inspection, a GP registrar (a trainee GP) was working at the practice.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access a local Out Of Hours GP service via NHS 111.

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 such as a colour coded system which easily identified patients and allowed a register to be maintained. 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. We saw practice safeguarding meetings involved health and social care professionals as well as the head of the local schools and their family liaison officers.
- 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, including advanced care plans for vulnerable or complex patients 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 held a range of meetings over each month. For example, palliative care, safeguarding, significant events including new cancer diagnosis and multi-disciplinary meetings.
- 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. However, external cleaning staff had access to areas such as consultation rooms out of opening times where blank prescriptions were accessible.
- Staff prescribed and 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 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 held six monthly medicines management meetings.
- Arrangements for dispensing medicines at the practice kept patients safe.

Good

Are services safe?

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 effective systems for reviewing and investigating when things went wrong. All practice staff were involved in team discussions around significant events. 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.
- The practice had used a nationally recognised cancer significant event audit. The tool prompted the GPs to reflect on their diagnosis, and identify any potential improvements in practice. The audit tool was used by clinicians to discuss new cancer diagnosis and patient deaths, and to learn so improvements could be made.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services effective?

We rated the practice as good for providing effective services overall except for people with long-term conditions and people whose circumstances make them vulnerable population groups which we rated outstanding for providing effective care.

We rated these population groups as outstanding for providing effective services because:

- The impact implementation of the gold standard framework for additional patient population groups had on the quality of care provided and positive patient outcomes.

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.
- The practice held morning meetings daily where any patient concerns were discussed.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Previously, the practice had implemented a pilot for a living better nurse (LBN), in partnership with local healthcare, social services and charities, to improve social networks and care provision for patients. Following its success, the local clinical commissioning group now funded this service across the GP federation. (A GP federation is a group of practices working together within their local area).
- The LBN worked three days a week and worked alongside GPs assessing patients, developing advanced care plans and liaising with other agencies.
- We saw the partners had made significant investment of time and team work to proactively identify patients with the greatest need and implemented changes to the management of these patient groups to improve the quality of care provided.
- In 2017, the practice received "going for gold accreditation" for the Gold Standards Framework (GSF) implementation. The GSF is a quality improvement programme which is influential in end-of-life care (EOLC). We saw the practice demonstrated enhanced EOLC including earlier identification of patients, more advance care planning discussions and improved outcomes for more patients which led to provision of high quality care and improved patient choice.
- In addition, they had adopted this framework for patients with complex medical care / long term conditions and frail patients (Silver patients) and vulnerable patients. Patients were provided with extended GP appointments so the GP could address medical complexities, and risks such as falls as well as develop treatment escalation plans and advanced care planning. All patients within the gold and silver patient lists had their own folder containing information relevant to their care and advanced care plans and where necessary referred to the LBN.
- All patient reviews included the use of a distress thermometer, a rapid screening tool for assessing psychological distress (normally used for cancer patients).

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. If necessary they were added to the practice vulnerable patient list.
- 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.
- Patients with complex or multiple long-term conditions were managed within the practices' own 'silver'

framework which the practice had adapted from the national gold standard framework (GSF). For example, patients benefitted from advanced care planning, referral to the living better nurse and a folder containing specific information relevant to their care. The management framework reduced hospital admissions, drove improvements in local care standards and encouraged multi-disciplinary working.
- 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 hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice's performance on quality indicators for long term conditions was in line with or above local and national averages. For example, we saw significantly positive variations for asthma and diabetes care.

Families, children and young people:

- Childhood immunisation uptake rates were below the target percentage of 90% or above. We saw that one of the 19 families registered had declined vaccination which resulted in a reduced average score.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. All failure to attend appointments were discussed within the practices' safeguarding meeting which was attended by health visitors and the head teacher for the local federation of schools.

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

- The practice's uptake for cervical screening was 73%, which was below the 80% coverage target for the national screening programme and slightly above the national average of 72%. The practice had a higher than average number of patients who had declined screening. To improve uptake the practice nurse offered two early morning clinics a week.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- Patients had access to appropriate local 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 using the Gold Standards Framework (GSF) which considered 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, dementia, mental health and those patients in receipt of social care.
- Patients known to be vulnerable were managed under the practices' 'vulnerable' GSF which they devised from the national gold standards framework. The practice had adapted the GSF for all vulnerable patients. This meant 80 patients had their needs met through receiving more joined up individualised care which took account of their preferences. The framework utilised several tools to identify the patient group and assess risks.
- The practice discussed new cancer diagnosed patients at their palliative care meeting.
- 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.
- Patients were managed under the 'vulnerable' GSF which meant advanced care plans were in place, mental capacity assessments routinely completed and additional tools were used to identify risks.
- 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 offered annual health checks to patients with a learning disability.
- Patients with dementia received an annual health check and were discussed monthly as part of safeguarding and GSF work. They were referred to the living better nurse for additional support.
- The practices' performance on quality indicators for mental health were slightly below national averages and above local averages. We looked at the practice data and some sample care records and saw effective processes to monitor practice performance. We saw they had reviewed and improved since the introduction of the GSF. The practice had a small number of patients with mental health and three of these patients had been appropriately exempted from the quality process which reduced the practice's results. Those patients were regularly monitored by other healthcare services.

Monitoring care and treatment

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

- Since April 2017 the practice has joined the local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). SPQS measures quality and outcomes differently. (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). SPQS focuses on outcomes rather than outputs or processes, offers practices the opportunity to redesign their services to deliver benefits to patients and focuses on the delivery of a person-centred care approach.
- QOF achievement for 2016/17 was 548 out of 559 points which was higher than the local average of 413 points and national average of 539 points. We saw the exception rating for some long term conditions indicators were higher than the national average for 2016/17. We reviewed the overall and individual exception reporting with the GP partners and found adequate rationale for all patient exclusions.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity such as the project for complex care management and the development of a plan-do-study-act (PDSA) method to evolve the gold, silver and vulnerable patient frameworks.
- They had monthly process in place to identify new patients, which included recent discharges from hospital, new cancer diagnoses and newly coded "severe frailty" (using a combination of best practice tools).
- The practice had undertaken a full evaluation and assessment of their systems and process in relation to the gold standard framework. This included clinical audits, qualitive feedback from carers and external organisations and reviews of meeting minutes and actions.
- Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Outstanding ☆

Are services effective?

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice had received national accreditation by demonstrating quality end of life care in line with the national end of life care strategy and NICE quality standards in end of life care. They were one in 20 practices nationally to achieve this. They had regular structured team meetings with involvement from outside agencies and encouraged sharing of information through advanced care planning.

Helping patients to live healthier lives

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

- The practice identified patients who may need 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 and the living better nurse.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice engaged in national projects such as the national diabetes prevention programme.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. They had set up a "healthy walking" group which was run by 40 volunteer patients.
- The partners used social media and blogs to encourage healthier living.

Consent to care and treatment

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results (2017) were above local and national averages for questions relating to kindness, respect and compassion. Four out of 10 indicators were significantly above averages. For example, 92% of patients stated the GP treated them with care and concern (national average 85%) and 98% of patients stated the nurse treated them with care and concern (national average 90%).

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.
- The practice's GP patient survey results (2017) were above local and national averages for questions relating to involvement in decisions about care and treatment.

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 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 were more vulnerable or who had complex needs through the living better project and complex care nurse. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a delivery service, weekly or monthly blister packs, large print labels.
- The practice hosted a chiropody, clinical psychologist, hearing aid audiology, an optician, an osteopath, talking therapies, a carer's group and the local advisory bureau.

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.

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 health and social care services to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Children in need could be referred to a local support group run by an educational psychologist.
- The practice held a register of families living with domestic violence or abuse.
- Health visitors ran clinics from the practice, promoting more coordinated care for families.

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.

People whose circumstances make them vulnerable:

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led mental health and dementia clinics. Patients who failed to attend or fail to collect

Good

Are services responsive to people's needs?

prescriptions were proactively followed up by a phone call from a GP where necessary, added to the vulnerable patient list and discussed at a monthly safeguarding meeting.
- The practice hosted community mental health worker appointments for those patients who had difficulty travelling.

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.
- The practice had implemented GP led complex care clinics with allow for dedicated time to review those patients with complex needs.
- Patients reported that the appointment system was easy to use.
- The practice's GP patient survey results (2017) were above local and national averages for questions relating to access to care and treatment. Some indicators were significantly positive. For example, 98% of patients responded positively to the overall experience of making an appointment (local average 77% and national average 72%) and 96% of patients stated they could get a clinical appointment when they needed one (local average 81% national average 75%).

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and 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. One GP was undertaking a local clinical leadership programme.

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. This included weekly partners meetings.

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.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

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

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.
- 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. Audit results were shared with other local practices.
- The practice had plans in place and had trained staff for major incidents.

Good

Are services well-led?

- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. 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. The practice involved the whole team in discussions around significant events. GPs used a national significant event tool to review care and treatment for all new cancer diagnosis and palliative care deaths.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice manager was involved in an accelerated learning tool programme which met regularly to critically reflect upon current work issues and identify solutions.
- We saw a significant investment of time and team work to enable the Gold Standard Framework to be implemented (Going for gold). This was evaluated, adapted and widened to include complex and vulnerable patients. The practice had received accreditation for their work to improve patient care through GSF.

Please refer to the evidence tables for further information.