East Quay Medical Centre

Inspection report

East Quay
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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 11 November 2014– Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at East Quay Medical Centre on 15 May 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice supported research and invested time in participating in local and national pilots to improve care. For example, a self-referral physiotherapy service, enabling access for patients with a diabetes secondary care practitioner, virtual cardiology clinics and visiting paediatrician clinics.
- The practice invested in continuing to provide the service of the NHS Navigator role to support patients' access the right care and support.
- The practice worked with the other members of the federation to invest in the Village Agent to support patients in the community.
- The partners at the practice held personal lists of patients which supported continuity of care for patients.
- GPs and the practice manager took on other roles outside of the practice to enhance their knowledge and skills to share and bring back to the practice. This was through taking on lead roles with the clinical commissioning group, Somerset Primary Healthcare, GP training and the Local Medical Committee.

We saw areas of outstanding practice:

- A new 'drop in' session has been developed for patients with memory loss and dementia.
- The practice manager created an open link via telephone or email for patients who need extra emotional support. This helped patients when they were anxious and enabled some issues to be addressed in advance or de-escalate concerns that they may have.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example, through social prescribing schemes and local initiatives. These included health walks, pilots for diabetes self-care. The practice was working on a mentor scheme with personal trainers through the Somerset Activity & Sports Partnership to help support young people with self-worth issues join in physical activities.

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

- The practice should continue to monitor that the Patient Group Directions (PGDs) for vaccines and immunisation documentation to support staff to deliver treatment is complete and up to date.
- The practice should continue to monitor the new system and process for the safe management of prescription paper and pads that was implemented during the inspection is appropriately implemented.
- The practice should include clearer information in the infection control audit could as to why aspects of the audit tool do not apply. For example, the type of hand wash facilities available did not match current good practice guidelines for public or clinical areas.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector.
The team included a GP specialist adviser.

Background to East Quay Medical Centre

The name of the registered provider of East Quay Medical Centre is East Quay Medical Centre.

The service is provided from one address at East Quay, Bridgwater, Somerset TA6 4GP and delivers a primary medical service to approximately 14,907 patients.

The practice is situated in a purpose built building near the centre of the town of Bridgwater which it shares with other services such as a NHS Dental Service, an independent health surgical and treatment service and an ophthalmology service. Information about East Quay Medical Centre can be found on the practice website www.eastquaymedicalcentre.com.

Information from Public Health England shows the area population is in the second least deprived decile in England. The practice population has a lower number of income deprived children. But higher for income deprived older people. The practice population of children and older people is similar to local and national averages. The practice population of those of working age are similar local and national averages. Of patients registered with the practice, 93% are White or White British, 0.7% are Asian or Asian British, 0.1% are Black or Black British, 0.8% are mixed British and 0.1% are Other.

The practice team is made up of 12 partners of which three are full time, overall the practice has the equivalent of just over 8.6 WTE GPs at the practice, five male and seven female. There are six practice nurses and four health care assistants. The practice manager is supported by a deputy practice manager, administrators, secretaries, and reception staff. The practice also employs specific staff for the management and administration of prescriptions, domestic and caretaking.

When the practice is not open patients can access treatment via the NHS 111 service.

The practice provides family planning, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. However, clearer information could be recorded as to why aspects of the audit tool do not apply. For example, the type of hand wash facilities available did not match current good practice guidelines for public or clinical areas.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- The Patient Group Directions (PGD's) documentation to support staff to deliver treatment was incomplete. Some were not signed by the authorising manager and some were out of date. These concerns were addressed satisfactorily during the inspection.
- The practice had safe systems for storage and for recording the movement of prescription paper at the practice. Although stored safely at the practice the logging systems for prescription pads (used infrequently) for GPs home visits could not be found. A new system and process was implemented during the inspection and we were informed that an audit would be carried out to check that prescription pads were still required.

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.

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.) The practice had opted out of fully using the national Quality and Outcomes Framework (QOF) to provide a baseline or register of patients at higher risk and need for support. QOF is a system intended to improve the quality of general practice and reward good practice. However, they were using a scheme that Somerset Clinical Commissioning Group had implemented, the Somerset Practice Quality Scheme (SPQS). The aims of the scheme were to actively monitor performance and improve the quality of general practice). We used information from both QOF and SPQS to establish the outcomes for patients.

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 appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who 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 clinical review including a review of medication.
- Care plans were in place for those patients who were considered at risk or have specific needs.
- The member of staff called the NHS Navigator regularly telephoned these patients assessed at risk, checked on their wellbeing and was able to monitor changes in their frailty.
- 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. They 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.
- District nurses and the Hospice nurses were encouraged to drop in on the daily morning meetings to share information.

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 their condition.
- 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 in line with the target percentage of 90% or above.

Good

Are services effective?

- 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 78%, which was in line with the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line 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 health assessments and checks. 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.
- 83% 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.
- 95% 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 of 91%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 95% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. A programme of regular audit was in place including reviewing medicines and prescribing, A&E attendances, care of patients with long term conditions, and the outcomes of referral processes for patients to mental health and talking therapies services. Where appropriate, clinicians took part in local and national improvement initiatives. For example, antimicrobial prescribing.

- QOF results were better than national levels for childhood immunisations.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.

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. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed 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 had 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 and local initiatives. These included health walks, pilots for diabetes self-care and working on a mentor scheme with personal trainers to help support young people with self-worth issues.
- 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.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Please refer to the Evidence Tables for further information.

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 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.
- All patients had a named GP, staff took care to ensure that they saw their own GP when making an appointment, including urgent on the day appointments. The practice told us that 85% of the practice population saw their own GP.
- Daily morning meetings for clinicians included the involvement of the district nurses and the hospice nurse which meant that information was shared and discussed in regard of meeting patient's needs.
- The practice had a member of staff called the NHS Navigator who acted as a link in regard of patients who were assessed as vulnerable or at particular risk. They acted as a communication link, keeping in contact with patients and seeking support from the necessary clinicians or other services to assist when required.
- Two members of the practice staff set up a Sunday afternoon 'tea and cake' group for isolated patients. The group was so successful it was handed over to a voluntary group to continue.

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 has instigated care plans for patients particularly those who were frail or vulnerable which were shared with pertinent others such as out of hours and district nurse teams.

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.
- The practice has focused on training for staff in regard to diabetes care and changing how they assess and monitor patients with pre-diabetes and diabetes. So that those with more than two risk factors had extended or appropriate time with the practice nurse to review all aspects of their care.
- A series of pilots were in progress including supporting patients at risk of diabetes using fitbits, remote coaching and support groups. The practice were in the process of rolling out a web tool for diabetics called MyDiabetesMyWay linking education and learning with their medical information.
- The practice is running a pilot with a local expert secondary care respiratory nurse who attends the practice for three sessions a month. A joint clinic was run for targeted patients, those with more complex needs, reducing the need for some patients to attend hospital, and enabling them to be managed well at practice level.
- The practice had been working with a local cardiologist on a virtual cardiology clinic. This meant that clinicians could have constructive conversations about patients care and more targeted plan of assessment and treatment for individual patients.

Families, children and young people:

Are services responsive to people's needs?

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice works with a local Pediatrician holding an outreach clinic at the surgery every two months. Specific patients were referred to the clinic and their needs expedited or they were signposted at an earlier stage than waiting for an outpatient appointment.

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 they offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours, early appointment and Saturday appointments. This had now been extended to within the federation so that patients could have the option of attending another practice should they need to.
- GPs could arrange with the patient a telephone consultation at a time convenient to the patient.
- Specialist clinics were offered on Saturdays, such as influenza vaccinations. The practice told us they were planning in the future to offer some contraceptive appointments on Saturdays.

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.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The NHS Navigator worked with the practices Village Agent (jointly funded across the federation to support patients in the community). The Village Agent, a non-medical service, was intended to replace some of the roles of friends and family and communities provide with social isolation, support and advice. Information was shared between these two roles and there was a collaborative approach to identifying patients of concern. For example, a vulnerable but reliable patient failed to turn up to an appointment. The NHS Navigator highlighted their concern to the Village Agent to check on the patient's wellbeing. The patient was found to have fallen the night before and unable to get up. After a hospital admission the patient now accepted help and was also addressing their social isolation.

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.
- Staff had training for supporting people with dementia and were 'dementia friends'.
- A new 'drop in' session had been developed for patients with memory loss and dementia.
- Care plans were in place for people with dementia and significant mental health needs.
- The local mental health worker attends the morning meetings periodically to share and catch up with patient's needs.
- The practice was working on a mentor scheme with personal trainers through the Somerset Activity & Sports Partnership to help support young people with self-worth issues join in physical activities.
- The practice manager created an open link via telephone or email for patients who need the extra emotional support. This helped patients when they are anxious and enabled some issues to be addressed in advance or de-escalate concerns that they may have.
- One of the GPs has taken on the role as the Clinical Commissioning Group (CCG) lead for mental health which has led to increased knowledge and information shared to improve services.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a request for an urgent appointment was made but mistakenly refused by new member reception staff taking the call, who didn't take the patients details, and patient was directed to the minor injuries service. This meant that the practice could not contact the patient to advise them properly at the time. The practice apologised, and staff were reminded of the fundamental principles in place, and issues were addressed through supervision and support for staff.

Please refer to the Evidence Tables for further information.

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.
- All of the 12 GPs were partners and there was a strong approach to equitable management of the service, including a system of opportunity through an annual rotation role as chair.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

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

Governance arrangements

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

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

Managing risks, issues and performance

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

Are services well-led?

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

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice supported research and invested time in participating in local and national pilots to improve care. For example, a self-referral physiotherapy service, enabling access for patients with a diabetes secondary care practitioner, virtual cardiology clinics and visiting paediatrician.
- The practice invested in continuing to provide the service of the NHS Navigator role to support patient's access the right care and support.
- The practice worked with the other members of the federation to invest in the Village Agent to support patients in the community.
- GPs and the practice manager took on other roles outside of the practice to enhance their knowledge and skills to share and bring back to the practice. This was through taking on lead roles with the clinical commissioning group, Somerset Primary Healthcare, GP training and the Local Medical Committee.