

# Ivel Medical Centre

## Inspection report

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

## Ratings

### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

# Overall summary

## **This practice is rated as Good overall.**

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 Ivel Medical Centre on 24 April 2018 as part of our regulatory purposes.

At this inspection we found:

- The practice had good systems to manage risk so that safety incidents were less likely to happen. When incidents did occur, the practice learned from them and improved their processes.
- The practice had reviewed and developed an innovative skill mix within the practice. For example, they employed an emergency care practitioner (previously trained as a paramedic) who worked as part of the duty team, providing consultations to patients presenting with acute same day conditions.
- Although effective monitoring processes were in place, which included health and safety, infection prevention control, training and appraisals. During our inspection the practice was unable to provide evidence to demonstrate that an effective employee immunisation programme was in place. Specifically, evidence was not in place to demonstrate that relevant staff had been immunised against infectious diseases such as measles, mumps and rubella (MMR).
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered in accordance with evidence based guidelines. Support and monitoring was in place for nurse prescribers.
- Staff treated patients with compassion, kindness, dignity and respect. All staff had received equality and diversity training.

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Information on the complaints process was available for patients at the practice and on the practice's website. There was an effective process for responding to, investigating and learning from complaints.
- Staff had the skills, knowledge and experience to carry out their roles and there was a strong focus on continuous learning and improvement at all levels of the organisation. Staff we spoke with felt supported by the practice.
- The practice had systems and processes to manage and mitigate risks to patients and staff. However, during our inspection we found that the practice was not following some of their policies, for example there was no health and safety risk assessment undertaken and we also found gaps in training for a staff member in infection prevention control.
- Clinicians knew how to identify and manage patients with severe infections such as sepsis.
- We found that clinicians were using an ineffective system to deal with hospital correspondence which posed a risk if required actions were not followed up.
- We found that the practice did not display information about the Patient Participation Group (PPG) and bereavement support services in the practice.
- Arrangements for dispensing medicines at the practice kept patients safe.

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

- Ensure that an effective employee immunisation programme is in place so that staff working in general practice receive the immunisations that are appropriate for their role.
- Ensure there are clear systems of monitoring compliance with Dispensary associated Standard Operating Procedures.

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

## Population group ratings

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

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and an inspection manager.

## Background to Ivel Medical Centre

Ivel Medical Centre is situated in the Biggleswade area of Bedfordshire. The practice provides general medical services for approximately 12,600 patients living in Biggleswade and surrounding areas. The practice population is predominantly white British along with a small ethnic population of mixed race, Asian, black and other races. The practice has a higher than average working age population due to its location in the commuter belt for London.

The practice has five GP partners (two female and three male) and three salaried GPs (one female and two males). There are two practice nurses (female), two minor illness nurses (females), a practice matron (female) and an emergency care practitioner (male). The nursing team is supported by two health care assistants (females). There is a practice manager who is supported by an office manager and a clinical manager. The practice is also supported by a team of administrative and reception staff.

Ivel Medical Centre is a dispensing practice able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. The dispensary is open from 8.30am to 12.15pm and 2.30pm to 6.00pm Monday to Friday. There are four staff attached to the dispensary. The practice operates from a new purpose converted low rise building and patient consultations and treatments take place on ground level. There is a car park outside the surgery with disabled parking available.

The practice is open Monday to Friday from 8.00 am to 6.30pm. The practice offers a variety of access routes including telephone appointments, on the day appointments, home visits and advance pre-bookable appointments. Walk-in appointments are available Monday to Friday from 8.30am to 9.30am. When the practice is closed out of hours services are provided by the Herts Urgent Care and they are accessed via the NHS 111 service.

# 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 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). We saw posters advising patients of the chaperone service in all the clinical areas and the reception area.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- There was an effective system to manage infection prevention and control. However, the practice was unable to provide evidence to support that an effective employee immunisation programme was in place on the day of our inspection. Specifically, evidence was not available to demonstrate that relevant staff had been immunised against infectious diseases such as measles, mumps and rubella (MMR). This is particularly important to reduce the risk of transmission to vulnerable groups.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

## Risks to patients

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

- The practice had reviewed and developed an innovative skill mix within the practice. For example, the practice

had employed an emergency care practitioner (previously trained as a paramedic) and was able to provide patient consultations for acute same day conditions.

- 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.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed referral letters and clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

## 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. The practice kept prescription stationery securely and monitored its use.
- However, we found that the practice did not have a failsafe system for managing uncollected prescriptions. During our inspection we identified two prescriptions which had been uncollected, one of these dated back to January 2018. On further investigation staff were able to

## Are services safe?

assure us that patients had received their medicines as further prescriptions had been issued for medicines. We saw evidence to support this through the patient record system.

- Checking and managing uncollected prescriptions was not included in the practice's medicines policy. In response to our findings we were informed that the policy would be updated immediately, to include guidance for staff on the management of uncollected prescriptions to reduce the risk to patient safety.
- 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.
- We reviewed the records of patients who were prescribed medicines which required additional monitoring. All the records we looked at showed that patients were appropriately monitored before medicines were re-prescribed.
- 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.
- Arrangements for dispensing medicines at the practice kept patients safe.

### Track record on safety

- There were comprehensive risk assessments in relation to some safety issues. These included for example, fire and legionella. (Legionella is a term for a particular

bacterium which can contaminate water systems in buildings). Regular checks were completed and documented in relation to these areas and the environment.

- Although the practice had a good track record on safety, we found that their health and safety premises risk assessment was undertaken informally. We did however note that there was evidence of actions taken after assessment.

### Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. 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. Significant events were marked as complete when identified actions had been completed and were given a risk rating on the likelihood of reoccurrence.
- The practice shared learning, identified themes and took action to improve safety in the practice. For example, when a pharmacy picked up that a patient was still on medication that was not intended for long-term use, an investigation was undertaken and all clinicians were reminded to review all medicines with patients during medication reviews.
- 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.**

# Are services effective?

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

## **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' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We reviewed prescribing data for the practice and found they were comparable with other practices both locally and nationally.
- 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.
- The practice had employed an emergency care practitioner who works as part of the duty team consulting with acute same day conditions.

## **Older people:**

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Influenza, pneumonia and shingles vaccinations were offered to all older patients.
- Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services, and the practice matron. They were 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 health 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.
- The practice's Quality Outcomes Framework (QOF) data relating to long-term conditions including asthma, chronic obstructive pulmonary disease (COPD), and atrial fibrillation was comparable to the clinical commissioning group (CCG) and national averages. QOF is a system intended to improve the quality of general practice and reward good practice.
- QOF performance for diabetes related indicators was comparable to the clinical commissioning group (CCG) and slightly below the national averages.

## **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.
- 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 75%, which was slightly below the 80% coverage target for the national screening programme but was comparable to the CCG average of 74% and national average of 72%.
- The practice's uptake for breast cancer screening was comparable to the CCG average and national average and bowel cancer screening was also comparable to the CCG average and national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.



## Are services effective?

- 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 employed a practice matron who provided home visits for most housebound patients and co-ordinated with other professionals when needed.
- The practice held a register of patients living in vulnerable circumstances including those in a women's refuge, homeless people, travellers and those with a learning disability.
- Annual health checks were offered to patients with a learning disability. The practice had 63 patients on their learning disability register and 23 patients had received a health check in the preceding 12 months. The practice informed us that they send out at least three invitation letters to all patients who have not yet had their annual health checks.
- 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):

- 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. For example, prescriptions for patients with suicidal tendencies were issued only on a weekly or fortnightly basis depending on severity.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 89%, which was comparable to the CCG average of 90% and the national average of 91%.
- A mental health nurse from the trust saw patients experiencing poor mental health at the practice when needed.

- 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.

### 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. For example, the practice had undertaken two completed audits that demonstrated quality improvement in the past 12 months. One of these audits ensured that patients taking lithium were being monitored adequately.

The most recent published Quality Outcome Framework (QOF) results showed the practice achieved 91% of the total number of points available compared with the clinical commissioning group (CCG) average of 92% and national average of 96%. The overall exception reporting rate was 7% compared with the CCG average of 10% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. 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 informed us that individual members of the clinical team had areas that they were responsible for, to maintain the QOF achievement. Identified members of the administration team ensured patients were appropriately called to the practice for review.

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. For example, 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.

## Are services effective?

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, clinical supervision and support for revalidation.
- The practice ensured the competence of staff employed in advanced roles through regular 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.
- Dispensary staff were appropriately qualified and their competence was assessed regularly.

### 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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred to, 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.
- The practice could demonstrate that they held multi-disciplinary case review meetings where all patients on the palliative care register were discussed.

### 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 (referring patients to a range of local, non-clinical services).
- 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 and 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.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.

We received 42 Care Quality Commission patient comment cards, all of them were extremely positive about the service experienced. All the cards had comments and gave various examples referring to how the staff were professional and helpful and how patients felt they were treated with dignity and respect.

## **Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language.

- Staff communicated with patients in a way that they could understand, for example, we noticed that reception staff spoke quietly so that others could not overhear.
- Staff helped patients and their carers find further information and access community and advocacy services. The practice had identified 3% of their registered patients as carers. There was a carer's lead and a carer's noticeboard and carers were referred to other agencies for carers support services.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

## **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.
- The practice complied with the Data Protection Act 1998.
- Staff recognised the importance of maintaining people's dignity and respect.

**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. For example, they provided online services such as repeat prescription requests and advanced booking of appointments and telephone consultations.
- The facilities and premises were appropriate for the services delivered. All consultation and treatment rooms were on the ground floor and access enabled toilets were available.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

## Older people:

- All patients had a named GP who supported them in whatever setting they lived. For example, the practice has patients in three nursing and residential care homes; each home had an allocated GP who undertook weekly visits.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs and practice matron also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

## 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 and other health care professionals to discuss and manage the needs of patients with complex medical issues.

- All of the practice's housebound patients were on the practice matron's caseload to ensure that those patients received the same level of care as those attending 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.
- Appointments were available outside of school hours.
- A private area was available for nursing mothers wishing to breastfeed. Baby changing facilities were available.

## 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, the practice offered extended opening hours twice weekly from 7am to 8am and between 6.30pm and 7.30pm on Tuesdays and Fridays. Appointments were also available for three hours on one Saturday each month.
- Online appointment booking and repeat prescription requests were available.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

## 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.
- Home visits were available for this group of patients when needed.
- Flexible appointment booking and longer appointment times were available.

## 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.

## Are services responsive to people's needs?

- The practice had a register of patients experiencing poor mental health including people with dementia; all identified patients had access to an annual review in the practice or in their own home.

### Timely access to care and treatment

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

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

### Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- 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, following receipt of a complaint due to a lost referral letter the practice reviewed its processes and changed to an electronic referrals system, eliminating the risk of reoccurrence.

**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. They looked at different ways of working in response to problems experienced when trying to recruit GPs. For example, the practice had employed an emergency care practitioner (previously trained as a paramedic) who worked as part of the duty team, providing consultations to patients presenting with acute same day conditions.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

## Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. The practice's move into the purpose converted premises ensured that they continued to meet the needs of their growing practice patient list.
- 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. For example, from a sample of complaints we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment the practice offered affected people support, information and a verbal and written apology. 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. 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. There were identified lead members for different areas and all staff we spoke with were aware of who these were.

## Are services well-led?

- Although practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We found that the practice was not following some of their policies, for example the infection prevention control policy stated that staff were to train yearly but we found one clinical staff member who had gaps in their training. However, the staff member undertook their training soon after the inspection which was later evidenced. Similarly the health and safety policy stated that the practice should undertake a health and safety risk assessment of the practice, the practice could not evidence this on the day of inspection.

### Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Although the practice carried out clinical audits which demonstrated that they were performing to a high standard, we found that they were mainly quality assurance audits. The practice assured us that they intended to address this; in order to continue to improve on the quality of care of their patients.
- 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.
- Although Standard Operation Procedures for the dispensary were available, there was no formal confirmation of monitoring compliance with these. The practice informed us that they were going to review this.

### 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.

- There were consistently high levels of constructive engagement with staff and people who use services, including all equality groups.
- 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. For example, the practice placed a sign in reception every morning during peak times instructing patients not to stand too close to the reception desk to ensure privacy for patients being served by staff.
- There was an active patient participation group (PPG), the group met quarterly with the practice. We spoke with one member of the PPG who said that the practice was very responsive to feedback they spoke very positively about the practice. Information regarding the PPG was available on the practice website and on the practice information screen in the patient waiting area.
- The service was transparent, collaborative and open with stakeholders about performance.

### Continuous improvement and innovation

## Are services well-led?

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

- There was a focus on continuous learning and improvement at all levels within the practice. For example, one member of staff had been promoted from being a receptionist to finance and data administrator and now works as an office manager currently undertaking training in practice management paid for by the practice to enhance her skills.
- Nursing staff had been trained to use treatment pathways to manage some long-term conditions.

- 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.**