Cobridge Surgery

Inspection report

Cobridge Community Health Centre
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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 at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Cobridge Surgery on 1 October 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. However, their prescribing quality systems showed a small number of patients had not been monitored effectively.
- The practice had a proactive approach in helping patients to live healthier lives.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use but reported that they were not always able to access care when they needed it. The practice was reviewing the telephone access to the practice in response to patients concerns.
- Staff stated they felt respected, supported and valued and there was an open culture within the practice.
- There were clear responsibilities and roles of accountability to support good governance and management.
- There was a focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

- The practice nurse had implemented a proactive plan to increase the uptake of cervical screening within the practice population, particularly amongst patients whose first language was not English and patients with a learning disability. The practice nurse who is a Queen's Nurse was awarded a highly commended certificate at the Queens Nursing Annual Conference for this work, with this innovative project recently being published on NHS England 'Leading Change – Adding Value' website.

The areas where the provider should make improvements are:

- Review routine immunisations for all staff that have direct contact with patients, including reception staff, to ensure they are up to date.
- Consider ways of updating reception staff in the identification of a rapidly deteriorating patient and the escalation process to follow.
- Complete a formal risk assessment to record the processes GPs followed regarding assessment of emergency medicines taken on home visits.
- Introduce safety netting processes to support prescribing against all current national prescribing guidance and MHRA alerts.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser and an observing GP.

Background to Cobridge Surgery

Cobridge Surgery changed its legal identity from a single-handed GP practice to a partnership provider in May 2018. It is located in Cobridge, Stoke-on-Trent. The practice provides care and treatment to approximately 5,170 patients of all ages and holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. It delivers services from one location which we visited during our inspection:

- Cobridge Surgery, Cobridge Community Health Centre, Church Terrace Stoke-on-Trent, Staffordshire, ST6 2JN.

The practice is in an area of high deprivation being in the first most deprived decile in the country. Demographically 27.4% of the practice population is under 18 years old which is higher than the national average of 20.8% and 11.2% are aged over 65 years which is below the national average of 17.1%. The practice supports a diverse community with 70% white British and 30% of people from other nationalities. The percentage of patients with a long-standing health condition is 54.4% which is comparable with the national average of 53.7%. The practice is a training practice for GP registrars.

The practice staffing comprises of:

- Two male GP partners.
- A male GP registrar
- A female practice nurse.
- A practice manager and assistant practice manager.
- Five members of administrative staff working a range of hours.

GP telephone consultations are available for patients who are unable to attend the practice within normal opening hours. During the out-of-hours period services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

The practice offers a range of services for example, immunisations for children, child development checks, travel vaccinations, lifestyle advise and management of long-term conditions such as diabetes. Further details can be found by accessing the practice's website at www.cobridgesurgery.co.uk

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 the risk of abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from the risk of abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from the risk of abuse, neglect, 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. We saw there was no evidence of photographic identification in staff files. However, the practice manager informed us they had checked photographic identification at the time DBS checks had been applied for. They told us they would update files to ensure this was recorded in the appropriate place.
- There was an effective system to manage infection prevention and control. However, there was no evidence in staff files that a review of staff immunisation for infections other than hepatitis B, such as tetanus, polio, diphtheria and measles, mumps and rubella (MMR), had been completed.
- 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. The practice population size had increased over recent years and new housing estates were being developed close to the practice. The GP partners told us they were considering the employment of an advanced nurse practitioner to support them to meet the additional demand this could potentially place on the practice.
- 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. The practice nurse had developed a sepsis screening and action tool to support staff in the recognition and management of sepsis. Reception staff were aware of the red flags in the identification of a rapidly deteriorating patient and the escalation process to follow. However, they had not received any formal training.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Public health data showed that the practice was in line with the local and national averages of prescribing some antibiotics but higher for others. The practice told us they met regularly with the Clinical Commissioning Group's (CCG)

medicines optimisation team to review their prescribing rates. They told us they were proactively monitoring the prescribing of their antibiotics however they were unable to provide any data to support this on the day of the inspection.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. The GPs did not routinely take suggested emergency medicines on home visits. However, it was evident through conversations with the GPs that they reviewed the past and current medical history of a patient before a home visit was carried out and took any medicines they anticipated would be required. However, a formal risk assessment to record this was not in place.
- There was a system for receiving and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts. However, the practice was not able to demonstrate that their programme of quality improvement activity included routine reviews of prescribing against all of the current national guidance or, that guidance from MHRA alerts was fully incorporated into routine practice.
- Patients' health was monitored in relation to the use of medicines and followed up 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 safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. However, changes required following MHRA alerts were not always embedded into routine practice.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

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 75 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review either at the practice or at home, including a review of medication and a care plan to support their individual needs.
- The practice used a recognised risk assessment tool to identify patients at increased risk of hospital admission. These patients were pro-actively reviewed to ensure their needs were met.
- The practice followed up 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.
- The practice held regular meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of frail older patients or patients with complex medical issues.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review with the practice nurse to check their health needs were being met. Medication reviews were carried out by the GP. 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. For example, the practice nurse had a diploma in asthma care and had attended training and updates in the care of the diabetic patient. One of the GPs had a diploma in cardiology.
- 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 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) and high blood pressure.
- Overall, the practice's performance on quality indicators for long-term conditions was in line with local and national averages. The percentage of patients who had received a review of their asthma was above the Clinical Commissioning Group (CCG) and national average. However, the percentage of patients with diabetes whose overall blood sugar levels were not within the recommended range was below the CCG and national average. The practice was aware of this and were working with a diabetic consultant to review their care and treatment.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 95% or above.
- 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 below the 80% coverage target for the national screening programme. However, the practice nurse had been proactive in increasing the uptake rate through initiatives such as making every contact count and

providing information in several languages. Data showed that there had been an increase in uptake of cervical screening since the plan had been put in place. The practice nurse had been awarded an Innovation Award at the Queen's Nurse Conference for her proactive approach in this area.
- The practice's uptake for breast and bowel cancer screening was comparable 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 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 considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice offered annual health checks to patients with a learning disability. Appointments were made at quieter times of the day to reduce potential stress to patients. The practice used easy read leaflets to support patients with a learning disability to understand their care and treatment. For example, information regarding cervical screening or breast examination.

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.
- 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 antidepressant medicines were not available on repeat request for this group of patients.
- 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's performance on quality indicators for people experiencing poor mental health was in line with local and national averages.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice.

- The practice's overall QOF data was comparable with other practices. However, their exception reporting rate was higher than the CCG and national average especially for patients with chronic obstructive pulmonary disease who had had a review of their health by a health professional. We explored this with the GP partners who were aware of this and had taken measures to address it. The latest unverified QOF data for 2017/18 showed the exception reporting had significantly reduced.

The practice used information about patients' outcomes to make changes to patient care and treatment internally and externally to the practice. For example, the practice nurse is a member of the Evidence in Practice research group within Keele University. The group's aim was to identify, appraise and use best evidence to challenge traditional methods of delivering nursing care and treatment. The group had identified an increasing number of local reactions to the whooping cough vaccine in pregnant women. They were exploring the impact of the vaccine guidance for women who had multiple pregnancies and if this was a causative factor.

Effective staffing

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

Good

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long-term conditions, older people and patients with a learning disability.
- 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 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 and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. For example, palliative care and patients with multiple conditions.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions. They shared information with, and liaised, with community services, social services and carers for housebound patients. They shared information with health visitors 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. Reception staff were trained in care navigation to assist the flow of information received after patients were discharged from hospital. A designated person audited the effectiveness of this system. 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 had worked with GPs in the North Stoke locality to develop a booklet signposting patients to additional services of support for example, Age UK, the Carer's Hub and the Citizens Advice Bureau. These booklets were given to patients to try to reduce the demand on the A&E department.

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 referrals to lifestyle programmes and smoking cessation services.
- The practice nurse had applied for a grant to purchase two hand-held tablets to show information on healthy eating and exercises to patients with a learning disability.
- 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, the childhood immunisation schedule and bowel cancer awareness.

Consent to care and treatment

The practice obtained verbal 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.

Good

Are services effective?

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 treated people. This was supported by the 24 Care Quality Commission comment cards we received on the day of our inspection.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

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 for patients with a learning disability. The two GPs spoke several different languages to support the diverse population. The practice nurse had applied for a grant to purchase two electronic tablets to enable her to visually show patients health promotion advise to support the written information provided.
- Staff helped patients and their carers find further information and access community and advocacy services, for example the carer's hub. They helped them to ask questions about their care and treatment.
- The practice proactively identified carers at new patient registration health assessments, NHS checks and long-term condition health reviews.
- The practice's GP patient survey results were in line with the 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. A confidentiality room was available when required and reception staff described methods they used to maintain a patient's confidentiality. For example, they did not use patient names when using the telephone.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patients' 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. There was a lift for patients with impaired mobility to take them to the practice on the first floor.
- 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. They supported them to access services both within and outside the practice. For example, the practice told us how they had worked with local voluntary agencies to support a homeless people registered with the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. Minutes we reviewed supported this.

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. The practice was responsible for the provision of prescriptions for patients in a local care home. Patient care however was provided by another provider. We spoke with a representative from the home who told us that historically the practice was responsive in providing prescriptions for patients when needed. However, recently they had experienced a delay in receiving the prescriptions with several items incorrectly prescribed. The practice told us there were often incomplete requests for repeat prescriptions from the home and they were working with the new manager to address these issues.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual health review with the practice nurse to check their health needs were being appropriately met. Patients received annual medication reviews with GPs either at the request of the practice nurse, opportunistically or in response to blood monitoring.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- New patients were offered a new patient health check. Patients identified as having a long-term condition were followed up appropriately.

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.
- There was a system in place to follow up children that failed to attend for immunisations.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.

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, telephone consultations and online facilities to book appointments and request repeat prescriptions.
- The uptake rate for cervical screening had been historically low at the practice. The practice nurse had implemented systems to increase the uptake of cervical screening within the diverse population.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including housebound, children and adult safeguarding and those with a learning disability.

Good

Are services responsive to people's needs?

- 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 a register of patients with dementia or patients experiencing poor mental health.
- The practice signposted patients experiencing poor mental health to support services such as Healthy Minds.

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 telephone access to appointments was difficult. The practice was in the process of installing a new telephone system to address this issue.
- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available in the reception area and on the practice's website. 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, complaints and also 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 had effectively navigated the practice through a period of uncertainty and change. 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. For example, the addition of an assistant practice manager.

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 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 diverse needs of the practice population.

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.
- 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 either directly with the management, through appraisal or at staff meetings. They had confidence that these would be addressed.
- There were processes for providing staff with the development they needed. For example, reception staff had received training in care navigation to support the workflow throughout the practice. This included appraisal and career development conversations. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice actively promoted equality and diversity. All staff had received equality and diversity training and used this training to support patients from different countries and cultures. Staff felt they were treated equally.
- There were positive relationships between the staff and the management team.

Governance arrangements

There were clearly defined 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 and joint working arrangements promoted coordinated person-centred care.
- Staff were clear on their roles and accountabilities including safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

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. Learning from these was shared with staff at staff meetings.
- Clinical audits on the quality of care and outcomes for patients had been completed. However, a second cycle had not been completed to demonstrate the effectiveness of any changes made.

Good

Are services well-led?

- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. Patient views were captured through the friends and family test, in-house surveys and the patient participation group.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, diabetic performance data showed that the percentage of patients with diabetes whose blood sugar levels were within recognised limits was below the local and national averages. To address this issue the GPs were working with a diabetic consultant to review the management and treatment of these patients.
- The practice used information technology systems to monitor and improve the quality of care.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Leaflets were available at the reception desk informing patients how their data was used.

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 (PPG).
- The practice worked closely with the locality and GP federation to promote services to patients.
- The service was transparent, collaborative and open with stakeholders about performance.
- With the support of the PPG, the practice carried out an annual in-house patient satisfaction survey and acted on issues identified.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- 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 was not only proactive in managing, monitoring and improving outcomes for its own patients but it shared its learning nationally to drive improvements within primary care. For example, the practice nurse had received The Queen's Award for the development of an effective system to support the uptake of cervical screening. This innovation had been published on NHS England's website for other practices to adopt.

Please refer to the evidence tables for further information.