# Manor Health Centre - Dr S. Taylor

**Quality Report**

Liscard Village
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Website: www.manorhcwirral.nhs.uk

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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 service | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Good overall.** (Previous inspection January 2015 – 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

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

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

We carried out an announced comprehensive inspection at Manor Health Centre - Dr S. Taylor on 13 February 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.
- There were systems in place to mitigate safety risks including health and safety, infection control and dealing with safeguarding.
- 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 patients and treated them 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought patient views about improvements that could be made to the service; including having an active patient participation group (PPG) and acted, where possible, on feedback.

# Summary of findings

- Staff worked well together as a team, knew their patients well and all felt supported to carry out their roles.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

- The provider was aware of the requirements of the duty of candour.

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

- Review the practice's safeguarding policy to include reference or links to recent related legislation and guidance.
- Review the infection prevention and control policies and procedures to localise and ensure they are specific to the practice.
- Review the system for responding to safety alerts to ensure full documentation of actions taken.
- Review the systems in place in order to proactively identify patients who are also carers, in order to provide effective care for them.
- Review the storage of historic paper medical records to ensure it complies with relevant legislation and guidance and that they are safe from environmental damage.
- Review audit planning to include full cycle audits that are based on local and national priorities

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

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

| | |
|---|---|
| **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 |

# Manor Health Centre - Dr S. Taylor

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

A CQC lead inspector**.** The team included a GP specialist adviser and a shadowing GP.

## Background to Manor Health Centre - Dr S. Taylor

Manor Health Centre - Dr S. Taylor is located in a purpose built medical centre, in Wallasey. The registered provider of services is Manor Health Centre - Dr S. Taylor. They provide a range of GP services to local residents under an NHS personal medical services (PMS) contract.

The practice has a patient list size of 5,900 and is located in a more deprived area when compared to other practices nationally.

There is an independent chemist located within the health centre. Out of hours services are accessed by calling NHS 111.

Good

# Are services safe?

## Our findings

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

**Safety systems and processes**

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

- The practice had a range of risk assessments in place including fire, control of substances hazardous to health (COSHH) and Legionella. It had a range of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies and procedures were in place for the practice. There were other policies in place reflecting current guidance and legislation such as female genital mutilation and Prevent however the practice policies did not link into these or have links to local authorities safeguarding policies. There were local safeguarding flow charts in each clinical room and administration areas. These outlined clearly who to go to for further guidance.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- 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.
- The practice carried out staff checks, including checks of professional registration, where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- There was an effective system to manage infection prevention and control. Cleaning schedules, including clinical equipment and general environmental cleaning, were in place and monitored. A range of infection prevention and control policies and procedures were implemented, however these were local to another provider and not specific to the practice. An infection prevention and control audit had been undertaken. There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed. We were told they carried out periodic checks of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to ensure the professional registration of staff. We saw evidence that clinical staff were up to date with their professional body revalidation and had appropriate professional indemnity cover to carry out their role.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinical staff knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

The service had adequate arrangements in place to respond to emergencies and major incidents:-

- Staff received annual basic life support training.
- The service had an oxygen cylinder with adult masks and there were also first aid kits and spillage kits available.
- Emergency medicines were available and suitable for purpose.
- The service had a defibrillator that was checked.

**Information to deliver safe care and treatment**

Good

# Are services safe?

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 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.
- Referral letters included all of the necessary information.
- Patient paper records were stored securely in a locked room, however these were stored on open shelves and not safe from the risks of environmental damage such as fire and flood.

**Safe and appropriate use of medicines**

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

**Track record on safety**

The practice had a good safety record.

- There were 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 that led to safety improvements.
- Arrangements were in place to receive and comply with patient safety alerts, recalls and rapid response reports issues through the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS). These were reviewed and acted upon where relevant. In some cases the action taken in response to safety alerts was not fully documented.

**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 and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. We discussed examples of incidents and significant events and found that learning had taken place and improvements to practice implemented as a result.
- The practice learned from external safety events as well as patient and medicine safety alerts.

The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.

They kept written records of verbal interactions as well as written correspondence.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

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

**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.
- The practice was comparable to others for prescribing trends for:

The average daily quantity of Hypnotics prescribed per Specific Therapeutic group.

The number of antibacterial prescription items prescribed per Specific Therapeutic prescribing data.

The percentage of antibiotic items prescribed that are Cephalosporin's or Quinolones.

- 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 are 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.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Home visits took place to frail, elderly people and to people who were resident in local care homes.

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 was comparable to others for performance relating to long-term conditions for example, diabetes, asthma, COPD, hypertension and atrial fibrillation.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- Child health surveillance checks were completed and regular meetings held with health visitors.

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

- The practice's uptake for cervical screening was 74%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- They had effective safeguarding systems in place and good communication with other services for vulnerable people.

Good

# Are services effective?

## (for example, treatment is effective)

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

- 79% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- 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 (practice 97%; CCG 93%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 91%; CCG 96%; national 95%).

**Monitoring care and treatment**

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

The most recent published Quality Outcome Framework (QOF) results were 93% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 96%. The overall exception reporting rate was 14% compared with a 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 higher than average exception rate was attributed to the patient population, being more difficult to engage with. The characteristics of the patients treated by a practice (for example level of deprivation) can affect exception reporting.

- The practice used information about care and treatment to make improvements. National Institute for health and Care Excellence (NICE) and other relevant guidelines were considered and implemented. However there was no formal system for reviewing guidelines as a practice such as at regular clinical meetings.
- The practice was actively involved in quality improvement activity such as clinical audits. We saw examples of audits undertaken and these demonstrated where changes had been implemented improvements were made. Audits included for example, gastro intestinal disorders, hormone replacement therapy and antimicrobial prescribing. However there was no audit program or plan that was based on local and national priorities.
- 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.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, 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 that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

Good

# Are services effective?

## (for example, treatment is effective)

- 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.
- The practice was comparable to other practices for the percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- 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.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, 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.
- All of the 19 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and thirteen surveys were sent out and 116 were returned. This represented about 2% of the practice population. The practice was around average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG - 91%; national average - 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 89%; national average - 86%.
- 97% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 93% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 91% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

**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. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients 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 patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 90 patients as carers (0.9% of the practice list). This is below average and the practice was aware they needed to be proactive in identifying carers who were patients in order to fully support them.

- Staff were aware of and able to provide signposting to the various services supporting carers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent

Good

# Are services caring?

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.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were generally better than local and national averages:

- 89% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 91% and the national average of 86%.
- 91% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 98% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**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 extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and telephone consultations
- The practice improved services where possible in response to unmet needs, for example, by using a software package to analyse appointments and non-attenders and they reviewed the appointment system in response.
- The facilities and premises were appropriate for the services delivered. The premises were suitable for patients with limited mobility, babies and young children and those with impaired hearing.
- 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, 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 and extended 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 transport systems.

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.
- Flu vaccination clinics were held annually, during these clinics support services also attended such as carers support (WIRED).

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. Multi-disciplinary meetings were also held with other relevant agencies.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Baby immunisation clinics and child health surveillance checks were carried out on a regular basis.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and online services.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice supported students and invited them for their Meningitis C vaccination and saw students as temporary residents if they were away from home.

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.
- The practice cared for patients with a life limiting illness with a multi-disciplinary approach. They knew and understood the individual needs of these patients.

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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients with poor mental health were invited for reviews on a six monthly basis.

**Timely access to the service**

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

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

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above local and national averages. This was supported by observations on the day of inspection and completed comment cards. Three hundred and thirteen surveys were sent out and 116 were returned. This represented about 2% of the practice population.

- 86% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 76%.
- 83% of patients who responded said they could get through easily to the practice by phone; CCG – 76%; national average - 71%.
- 88% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 86%; national average - 84%.
- 90% of patients who responded said their last appointment was convenient; CCG - 85%; national average - 81%.
- 90% of patients who responded described their experience of making an appointment as good; CCG - 77%; national average - 73%.
- 69% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 58%.

**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 and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We reviewed a sample of complaints received in the last year 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. We saw examples where improvements to practice had been made in response to learning from complaints.

# Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Our findings

**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 had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a 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.
- We saw examples that demonstrated openness, honesty and transparency 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 had received appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was an emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. 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

# Are services well-led?

Good

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

- 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.

- 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 MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality. However audits were undertaken on an ad hoc basis and there was no formal audit plan in place that was based on local and national priorities.
- 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 arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However some patient paper records were not stored safely in order to minimise risks from environmental damage.

**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. Examples included analysis and review of Friends and Family Test results, national GP patient's survey results and internal GP surveys.
- There was an active patient participation group who worked well with the practice, were listened to and able to contribute to service developments.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the practice.
- The practice was a teaching practice and regularly supported medical students. They were currently considering becoming a training practice for trainee GPs.
- Staff knew about improvement methods and had the skills to use them.

# Are services well-led?

Good

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

- 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.