Glastonbury Health 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. (Previous rating June 2015 – Good)

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 at Glastonbury Health Centre on 20 November 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.
- Feedback from local care and nursing home services demonstrated that the practice worked well with them and provided support in the interest of the best outcomes for patients.
- The practice provided comprehensive support for patients with mental health needs, personalised long-term care plans were in place and they worked well with other mental health professionals with a 'shared care' approach.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice has continued working with endeavouring in reducing their impact on the environment with a 'Green Impact' policy and ways of working. Recently working with a Deanery Scholarship Registrar, they had been looking at changes they could do to reduce paper use, recycling inhalers and providing energy advice to patients.

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

- The provider should continue with developing aspects of well led with a central oversight of staff's immunisation status, training for staff in respect of fire safety and trained fire marshals to maintain safety, monitor that their recruitment policy and procedure is followed.
- The provider should make changes to their registration with CQC in a timely way.
- The provider should continue to monitor cervical smear screening to meet Public Health England screening rates.
- The provider should continue to monitor childhood immunisation to meet Public Health England immunisation rates.

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 a practice nurse specialist adviser.

Background to Glastonbury Health Centre

Glastonbury Health Centre is provided from one address, 1 Wells Road, Glastonbury, Somerset BA6 9DD and delivers a personal medical service to approximately 6,194 patients. The practice is situated in a purpose-built building near the central area of Glastonbury, public parking is adjacent to the health centre. Information about Glastonbury Health Centre can be found on the practice website www.glastonburyhealthcentre.co.uk.

Information from Public Health England (2016/2017) indicates that the practice area population is in the fifth most deprived decile in England. The practice population of children is below local and national averages at 17%. The practice population of working age at 61% is similar to the local and national averages at 62%. The practice population of patients living with a long-term condition was above the local and national averages at 59%, the local being 57% and national being 54%. Of patients registered with the practice, 98% are White or White British, 0.7% are Asian or Asian British, 0.2% are Black or Black British, and 1.2% are mixed race and Other 0.1%.

The provider has told us the practice team is made up three GP partners, two male and one female. There is one advanced nurse practitioner (ANP) and three practice nurses and two health care assistants. The practice manager and the deputy practice manager are supported by a team of administrators, secretaries, and reception staff.

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

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

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse. However, the practice needed to ensure it followed its own recruitment and employment policies and procedures.

- 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. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice did not follow its own recruitment policy and procedure in regard retaining evidence that appropriate staff checks at the time of recruitment and on an ongoing basis were carried out. Information was not always held centrally with the individuals personnel record but within tasks or systems such as application for SMART cards or DBS checks. The information regarding the locum GPs employed directly by the practice was incomplete as information was out of date and some information had not been sought or checked such as proof of identity, training and immunisation status. Following the inspection, the practice told us that they had ensured the information regarding staff records had been centralised. This meant there was an appropriate record of the individual that included the required information. The practice had also amended its recruitment policy and procedure to reflect the changes it had put in place.
- There was an effective system to manage infection prevention and control. However, it had been identified that information regarding staff immunity status was incomplete and they were part way through audit and checks to ensure information is obtained.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. A review of staff skill set identified that none of the current staff had undertaken recent fire warden training, although prompt cards were available, the practice manager identified that e learning was available and would be undertaken by staff as part of their regular training.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

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

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

Good

Are services safe?

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and took action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were 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.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

The practice intends to continue with Quality Outcomes Framework (QOF) parallel with using aspects of the Somerset Practice Quality Scheme (SPQS) to enable patients to receive a person-centred approach to managing their health care needs. The QOF is a voluntary reward and incentive programme. It rewards GP practices, in England for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care. This is particularly pertinent to the patient population they serve as it has a higher than average number of patients who have differing beliefs and lifestyle where conventional medical support is not always used.

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 managed to deliver care and support at the same time meeting the specific needs of patients living in the Glastonbury area who had alternative views and lifestyle and didn't wish to participate in conventional medicine.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Feedback from local care and nursing home services supported that the practice worked well with them and provided support in the interest of the best outcomes for patients.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice had instigated an agenda of developing care plans for over 75s, and treatment escalation plans to reduce admission to hospital.
- 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 local practices and health and care professionals to deliver a coordinated package of care. Care planning was implemented to reduce the necessity of hospital admission.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisation uptake rates were below the target percentage of 90%. The practice nursing staff monitored closely the update and participation in the programme for childhood immunisations. They had utilised several methods of engaging with parents and guardians to encourage uptake of immunisations including opportunistic, personal letters and the provision of leaflets and information.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Failed attendance and engagement with parents or guardians were discussed regularly at team and multi-disciplinary meetings with the focus on joint working to achieve the best outcome for the patients.
- The practice held young person's diabetes clinics to encourage attendance for reviews of their care.

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

- The practice's uptake for cervical screening was 65%, which was below the 80% coverage target for the national screening programme. The practice were aware of this and were using personal contact with patients such as, other appointments, telephone calls and letters to encourage uptake.
- The practice's uptake for breast and bowel cancer screening was similar or below the national average. The practice staff were aware of this and were using personal contact with patients such as, other appointments, telephone calls and letters to encourage uptake.
- 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. The practice had estimated that during a five-year cycle they had achieved 51% screening rate. 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 a higher than average number (45) of homeless people register with them in the last 12months and worked with a homeless service in Wells to provide clinical care where able.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice staff had identified that it supported a higher number of patients, 2.2% of its practice population, with a significant mental health need such as psychosis or major mental health disorder. They undertook the lead on providing primary mental health support for patients in the area. The Clinical Commissioning Group had recognised the significant issues locally for Glastonbury and had provided financial support via a Local Enhanced Service agreement for the practice.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

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

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.
- The practice told us they were aware of the shortfalls of information regarding the QOF data. They could demonstrate that the data did not reflect the level of support they had provided to patients with long term conditions who required a programme of ongoing support. They were able to provide information of what

actions they were taking to address the issues which included ensuring correct coding of patients' needs in the patients records to assist with planning and delivering their support.
- The practice informed us that they were aware of the shortfalls in information regarding the QOF data which doesn't reflect the level of support they have provided to patients who fall into the categories of people that required a programme of ongoing support. The practice staff were able to provide information of what actions they were taking to address the issues which included ensuring correct coding of patients' needs in the patients records and audits to assist with planning and delivering their support.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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. This was particularly relevant the mental health patients, patients living with dementia and the care planning in place for patients with long term conditions to reduce inappropriate admission to hospital.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. This has included continuing with referrals to health connectors who directed patients to local schemes/ organisations to address social isolation and providing links with the 'village agents'.
- 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

Good

Are services effective?

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were above or in line local and national averages for questions relating to kindness, respect and compassion.

The practice staff had supported patients to obtain the benefits they were entitled to by providing letters and supporting information.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were above or in line local and national averages for questions relating to involvement in decisions about care and treatment. Patients expressed that they felt engaged and involved in the decision making about their care.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

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 multi-disciplinary teams including the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice engaged with patients identified with pre-diabetes indicators to improve their health and wellbeing, and referred patients to a diabetes prevention program.

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.
- The participated in multi-disciplinary meetings with the health visiting team reviewing and discussing children and families of concern.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had a policy of flexible/ walk in, same day contraception appointments for teenage girls and young women.
- The practice carries out chlamydia and sexual health screening within the practice because of limited local access.

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, working with other local practices to provide extended opening hours and Saturday appointments.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. Same day appointments are given for homeless people if they present asking to see a GP.
- The practice provide care in line with a 'shared care' arrangement with a clinic in Exeter for patients with gender dysphoria as they had a higher than expected number of patients identified as requiring support.
- The practice offered a substance misuse management service working with other organisations in a 'shared care' framework.

Good

Are services responsive to people's needs?

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 had flexible appointments, longer appointments for mental health and dementia needs. Patients who failed to attend were proactively followed up by a phone call from a GP.

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.
- The practices GP patient survey results were above or in line with local and national averages for questions relating to access to care and treatment.
- Patients told us they had timely access to care and treatment, although some expressed issues with obtaining appointments others had no concerns.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded/did not respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from the analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

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

Vision and strategy

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

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

Culture

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

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

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and in the most effective. Minor gaps in oversight of training records needed to be addressed. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care. However, the practice should continue working to ensure that children's immunisations and cervical smear testing rates meet with Public Health England's expectations.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, some were not followed completely, such as recruitment.
- Changes in the practice partnership had occurred, although the practice had delayed ensuring that these changes had been reflected in the registration with the CQC. We were informed these applications were in the process of being completed. An application to update the providers Statement of Purpose to reflect these changes had been made but was returned as the details were incorrect.

Managing risks, issues and performance

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

Good

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- 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.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. Outside speakers were invited on a bi-monthly basis to provide training and generate discussions and learning across the staff team.
- The practice was a training practice for trainee GPs from the Severn Deanery.
- The practice staff got involved in pilots and projects to improve the outcomes for patients such as aims to reduce the admission to hospital.
- The practice has continued working with endeavouring in reducing their impact on the environment with a 'Green Impact' policy and ways of working. Recently working with a Deanery Scholarship Registrar, they had been looking at changes they could do to reduce paper use, recycling inhalers and providing energy advice to patients.
- 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.