

Dingle Park Practice

Quality 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 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 

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 15 October 2014– Good overall)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

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 Dingle Park Practice on 16 March 2018 as part of our routine inspection programme.

At this inspection we found:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Care Quality Commission (CQC) comment cards reviewed indicated that patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. The practice constantly sought ways to improve the quality of care and actively monitored complaints, incidents, audits and survey results.
- Results from the national GP patient survey from July 2017 showed that patient's satisfaction with the service and how they could access care and treatment was much higher compared to local and national averages. For example, 97% of patients who responded would recommend this surgery to someone new to the area (CCG average 80%; national average 77%).
- There was a clear leadership structure and the practice was well organised. Staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour.

We saw areas of outstanding practice:

- The practice had identified previous immunisation uptake rates for children were low and had taken a

Summary of findings

proactive approach to tackle this by employing an additional member of staff-a child immuniser, improved the recall and alert system and ensured GPs had access to vaccinations to increase opportunistic vaccinations. This had resulted in a significant improvement and uptakes were 97%.

- The practice proactively supported patients to lead healthier lives. They had held a health awareness review week in 2015 when a variety of supporting agencies had been invited into the practice to help patients with their lifestyle to promote healthy living or address any social needs. This had been well received and the practice was planning a further event running for three weeks in April 2018.

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

- Review the system for ensuring all patient group directives for the administration of vaccinations are kept up to date.
- Review the prescribing policies so as to include information to staff for how to manage uncollected prescriptions.
- Review the patient information literature to include details of who patients can contact as an alternative to the practice if they wished to make a complaint.

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

Dingle Park Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dingle Park Practice

Dingle Park Practice is one of three practices located in the Riverside Centre for Health in a deprived area of Liverpool. The practice list size had increased by 10% over the past three years to approximately 4,900 patients at the time of our inspection and the majority (80%) were white British.

The staff team includes four GP partners, two salaried GPs, one assistant practitioner, two practice nurses and a healthcare assistant, a practice manager, an office manager and administrative and reception staff. The practice is a GP training practice and has a GP registrar working for them as part of their training and development in general practice.

Dingle Park Practice has a General Medical Services contract (GMS). The practice is part of NHS Liverpool Clinical Commissioning Group (CCG). Dingle Park Practice is the only practice commissioned to provide phlebotomy as part of the citywide community service (alongside Liverpool Community Health and the Royal Liverpool and Broadgreen University Hospitals Trust.)

The practice is open 8am to 6.30pm Monday to Friday. Patients accessed the Out-of-Hours GP service by calling NHS 111.

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 conducted safety risk assessments. It had a suite 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 were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding and safety training appropriate to their role. Staff from the practice attended clinical commissioning group (CCG) safeguarding forums to keep up to date with best practice. Staff knew how to identify and report concerns and the practice had a system on the computer to allow staff to flag up any concerns. The practice held regular monthly meetings with the health visiting team to discuss any safeguarding concerns. There were systems in place to monitor children who did not attend practice or hospital appointments.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing 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).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. There had been a recent external audit carried out by the local infection control and prevention team and were 98% compliant; there was an action plan to address any shortfalls.
- 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. The practice used an on call GP system so that there was a GP available who could specifically deal with unplanned care during the day to maximise patient access.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The practice had a defibrillator and shared oxygen with another practice. However, there was no formal arrangement in place for this at the time of our inspection. After the inspection, the provider informed us that they had purchased their own oxygen.
- 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 practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, out of hours services.
- Referral letters included all of the necessary information.

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.
- Patient group directions for the authorisation of vaccinations were available but we found one which expired in February 2018.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Are services safe?

- The practice managed uncollected prescriptions appropriately but there was no written protocol.
- The practice worked with the medicines management team and recent audit work showed the practice monitored patient's health 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 comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

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.
- There were 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. For example, there were improved systems in place for reviewing test results.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

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.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

Once patients were registered with the practice, the healthcare assistant or practice nurse carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The patient was referred to the GP when necessary.

The practice had systems to keep clinicians up to date with current evidence-based practice and discussed new guidelines at practice meetings.

- 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.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- 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.
- The practice had previously taken part in anticipatory care planning which helps reduce the pressure on A&E departments by treating patients within the community or at home instead of hospital. Even though funding had discontinued, the practice carried on with this system. Care plans were in place for these patients.

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.

- The practice worked with the Liverpool Diabetes partnership and this also helped to improve the skills of the clinicians. Monthly clinics were held to try to reduce the number of diabetic patients referred to secondary care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

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 97% above the target percentage of 90%.
- The practice had health visitors that attended the practice on a weekly basis. Communication log books were used and the practice had regular monthly meetings with the health visitor to discuss any concerns.

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

- The practice's uptake for cervical screening was 71%, which was in line with the 80% coverage target for the national screening programme. Regular audits were carried out to check screening was effective.
- 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 monthly gold standard framework meetings and monitored the work they were doing to ensure all patients passed away in their preferred place. Recent audit work demonstrated an improvement in this area and all patients identified had passed away in their preferred place. There were bespoke anticipatory and advanced care plans for patients which were shared with other services.

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice worked with a local scheme to help screen for chronic obstructive pulmonary disease in drug users.

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

- 84% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months (national average 83%).
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months (national average 90%).
- 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 93%; CCG 90%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 98%; 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.

The practice participated in the Quality and Outcomes Framework system (QOF). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice also monitored its performance with CCG targets, carried out clinical audits, such as improving 2 week referrals and worked with the local medicine management team.

The most recent published Quality Outcome Framework (QOF) 2016-2017 results were 100% of the total number of points available. Non verifiable data for 2017-2018 were also 100%. The overall exception reporting rate for clinical indicators was 8.4% compared with a national average of 9.6%. (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.) This practice was not an outlier for any QOF (or other national) clinical targets.

However, there was a positive variation in performance compared to local and national averages for patients with hypertension. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 92% compared with a local average of 84% and national average of 83%. The practice had a higher prevalence of patients with hypertension (16%) compared to the local CCG average (14%). There was also a significant positive variation in performance for caring for diabetic patients. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 95% compared with a local average of 83% and national average of 80%. The practice also had a higher prevalence of patients with diabetes (8%) compared to the local CCG average (6%).

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 ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.

Coordinating care and treatment

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

- Local CCG performance data demonstrated that the practice had lower A&E minor attendances and secondary referral rates compared to the local CCG averages.

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.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. Health promotion clinics were offered to patients. These included smoking cessation, drug user support and obesity management. The practice had plans to introduce 'walking sessions' for patients who had high BMI levels. Travel advice was also provided including common travel vaccinations.
- The practice had held a health awareness review week in 2015 when a variety of supporting agencies had been invited into the practice to help patients with their lifestyle to promote healthy living or address any social needs. This had been well received and the practice was planning a further event in April 2018.

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 health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

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.

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 18 patient Care Quality Commission comment cards we received were positive about the service experienced.
- NHS Friends and Family Test results from the past six months showed that from 49 responses, 48 were extremely likely to recommend the practice and one likely to recommend the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. From 388 surveys sent out, 129 were returned. This represented about 3% of the practice population. Results were higher than local and national averages. For example:

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

- 98% of patients who responded described their overall experience of this surgery as good (CCG average 89%; national average 85%).
- 97% of patients who responded would recommend this surgery to someone new to the area (CCG average 80%; national average 77%).

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 about vaccinations.
- 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.

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 177 patients as carers (3.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them and there was also information available on the practice website.

Staff told us that if families had experienced bereavement, their usual GP contacted them. 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. Information for help was also available on the practice website.

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 higher than local and national averages:

Are services caring?

- 95% 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 89% and the national average of 86%).
- 94% of patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 84%; national average 82%).
- 98% of patients who responded said the last nurse they saw was good at explaining tests and treatments (CCG average 92%; national average 90%).

- 95% of patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 88%; 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.

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 across all population groups.

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 had invested in more nursing provision for patient support. In addition, there was a high GP patient ratio compared with other practices in the area. This was to offer a high standard of care to patients and increase access to meet patient demand.
- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests and advanced booking of appointments.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice employed a nurse to specifically look after 80 patients who were housebound.
- Each housebound patient and nursing home patient had a named GP.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice had previously provided medical cover for an intermediate care unit for six months.
- The practice made effective use of the CCG multidisciplinary team to identify patients who may benefit from this service.

People with long-term conditions:

- There was a system to recall patients for a structured annual review to check their health and medicines needs were being met.
- There were systems in place to ensure eligible patients received flu, pneumonia and shingles vaccinations.
- The practice held monthly chronic disease management meetings to discuss issues and share new guidelines.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had a phlebotomy service onsite for convenience.

Families, children and young people:

- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics and provided immunisations.
- The practice had identified that the historical uptake of vaccinations were low and had employed a child immuniser to specifically address this issue. This had directly impacted on the uptake rates now being 97%, higher than the national target level of 90%.

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

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice was flexible in arranging appointments for patients who could not attend during normal working hours.

People whose circumstances make them vulnerable:

- The practice kept a register of patients with a learning disability and offered longer appointments for these patients.
- The practice regularly worked with other health care professionals and the local learning disabilities team in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations. For example, the practice recognised with changes in benefits, patients were in

Are services responsive to people's needs?

(for example, to feedback?)

difficulty. The practice engaged with a local homeless charity, to support patients, had citizen's advice bureau attend the practice on a weekly basis; and they were also a distribution point for food bank vouchers.

- The practice worked with the local alcohol and drug recovery team and made appointments for patients to coincide with their appointments with the team.
- The practice liaised with social inclusion and refugee teams.

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

- The practice was able to signpost patients experiencing poor mental health to access various support groups and voluntary organisations.
- The community mental health team held a clinic at the surgery which helped patient attendance and the GPs to be able to directly discuss cases with the psychiatrist.
- The practice offered flexible appointments for example at the end of surgery or the first appointment when patients were more comfortable attending.

Timely access to the service

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

The practice was open between 8am to 6.30pm Monday to Friday.

Results from the national GP patient survey from July 2017 showed that patients' satisfaction with how they could access care and treatment was much higher in some areas compared with local and national averages.

- 94% of patients said they could get through easily to the practice by phone (CCG average 75%, national average of 71%).
- 92% of patients described their experience of making an appointment as good (CCG average 77%, national average of 73%).
- 90% of patients who responded said their last appointment was convenient (CCG average 83%, national average 81%).
- 54% of patients who responded said they don't normally have to wait too long to be seen (CCG average 60%, 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. However, the patient complaints information leaflet did not have details of who patients could complain to instead of complaining directly to the practice.
- The practice kept a log of compliments and verbal and written complaints which were discussed at staff meetings so that any learning points could be cascaded to the team.

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.

Vision and strategy

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

- There was a clear vision to provide convenient access and continuity of high quality care based on up to date evidence. The practice aimed to deliver practice based care when possible and be proactive in care and health promotion. The practice planned its services to meet the needs of the practice population.
- The partners met on a regular basis to discuss business plans to achieve priorities.
- The practice worked with the CCG on various projects.

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. They had confidence that these would be addressed.

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Staff were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

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

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

Managing risks, issues and performance

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

- 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 MHRA 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 business contingency plans and had trained staff for major incidents.

Are services well-led?

Good 

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

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.
- There were 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 had tried on several occasions to set up a Patient Participation Group (PPG) but this was not always successful. The practice sought other means of gaining patient feedback such as utilising in-house patient surveys

and the Friends and Family test. The practice had acted on patient feedback for example; they had improved their telephone systems. The practice had a newsletter to keep patients informed of any changes and also used this as a way to communicate any health screening programmes.

The practice took into account suggestions from staff for improvements. For example, in making improvements to the practice web site.

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 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.