Fallodon Way Medical Centre

Inspection report

13 Fallodon Way
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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 inspection March 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

We carried out an announced comprehensive inspection at Fallodon Way on the 24 May 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.
- 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 had employed a care coordinator who acted as a communication link, keeping in contact with patients and seeking support from the necessary clinicians or other services to assist. Feedback from patients about this service was very good with patients expressing their appreciation about receiving contact especially following their discharge from hospital when they were feeling vulnerable.
- The care coordinator set up a 'tea and talk' group for isolated patients and coordinated a volunteer driver service to assist patients to the practice and to secondary care appointments.

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

- Review the process of exception reporting for the quality outcome framework.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

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 CQC lead inspector; the team included a GP specialist adviser.

Background to Fallodon Way Medical Centre

Fallodon Way Medical Centre

13 Fallodon Way

Henleaze

Bristol BS9 4HT

www.fwmc.org.uk

Fallodon Way Medical Centre is a partnership of three GP partners providing primary care services to over 9000 patients in and around Henleaze in the north west area of Bristol. The practice is experiencing an increase in patient numbers, by approximately 5% over the last three years. It is one of the least deprived areas of the country; the Index of Multiple Deprivation 2015 score is 10. In England, people living in the least deprived areas of the country live around 20 years longer in good health than people in the most deprived areas. The patient group is of mainly white origin with 8.5% of people in the practice area are from black or minority ethnic groups.

There are three GP partners, four salaried GPs and one retained GP working at the practice. In addition, there are four practice nurses and three healthcare assistants; a pharmacist and a care coordinator. They are supported by an administration and reception team overseen by the practice manager.

Vasectomy and minor surgery was undertaken at the practice as part of a separate independent health contract which falls under the registration for GP Care UK Ltd and is not included in this inspection.

The provider is registered for the following regulated activities:

Surgical procedures

Maternity and midwifery services

Diagnostic and screening procedures

Family planning

Treatment of disease, disorder or injury

The practice does not provide out of hours services, these are accessed through the NHS 111 service which is advertised on the patient website.

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.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- 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. There was a documented approach to managing test results.
- 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.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice pharmacist monitored safe prescribing by the practice and undertook reviews to optimise medicine usage and minimise over prescribing.
- The practice had reviewed its antibiotic prescribing and taken 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 comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

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 .

(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

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed 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 used appropriate tools to assess the level of pain in patients.
- 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. 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 routinely sent a health and well-being questionnaire to all patients once they reached the age of 75. This enabled them to identify any potential issues and have contact with people who rarely attended the practice. 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. All GPs and the care coordinator were involved in a daily meeting where the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.
- The practice appointed a care coordinator to provide support to clinical staff in the practice to ensure frail elderly patients obtained the support and care necessary to reduce the risk of unplanned hospital admissions and to support and enable safe and timely discharge from hospital.

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 offered home visits and rapid access appointments for those with enhanced needs.
- 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.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity 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 they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice exception reporting levels were higher than national average but in line with CCG average for most indicators for long term conditions.

Families, children and young people:

Good

Are services effective?

- 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% for all four indicators. Three of the four indicators were over 95%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 82%, which was in line with the 80% coverage target for the national screening programme and above local and national averages.
- The practices' uptake for breast and bowel cancer screening was higher than the national average. For example, the practice uptake for bowel screening was 69% whilst the national average was 54%.
- 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.
- 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 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.
- 94% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%.
- 100% 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 above the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 91% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- 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. For example, they reviewed the treatment of patients with osteoporosis whereby 43 patients were identified and invited to attend the practice for a review. From this, seven

patients had treatment started, two had treatment stopped, 10 had treatment requested and all 28 had bone health lifestyle advice given (including 10 with advice alone).

Where appropriate, clinicians took part in local and national improvement initiatives. For example, they were involved in the NHS England locality and CCG prescribing participation scheme.

- We found for 2016/17 some exception rates for some indicators were significantly higher than the CCG or national averages. We discussed this with the practice and noted that the system by which patients were excepted needed to be reviewed to prevent it being too much of an administrative process leading to over reporting.
- 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.

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. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate.
- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The 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.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Good

Are services effective?

- 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.

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.
- GP patient survey results for the practice indicated that 100% of people had confidence and trust in the last GP they saw or spoke to which was better than CQC or national averages. The practice scored above local and national averages for patient satisfaction in all indicators (included in the evidence table) for kindness, respect and compassion.
- The practice had employed a care coordinator who acted as a communication link, keeping in contact with patients and seeking support from the necessary clinicians or other services to assist. Feedback from patients about this service was very good with patients expressing their appreciation about receiving contact especially following their discharge from hospital when they were feeling vulnerable.
- The care coordinator set up a 'tea and talk' group for isolated patients. This took place on a monthly basis and included a guest speaker who covered a variety of subjects.
- The practice had a volunteer driver service to assist patients to the practice and to secondary care appointments.

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 those 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.
- 93% percent of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care which was better than CQC or national averages.
- 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.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- 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. They offered home visits and rapid access appointments for those with enhanced needs.
- All GPs and the care coordinator were involved in a daily meeting where the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.
- 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.
- The practice had improved its position within the clinical commissioning group in respect of the GP patient survey question relating to overall experience of the GP practice to 1at place in 2015/16.
- Data from One Care showed the practice had lower than average use of out of hours services by patients with demand per weighted population at 0.09 compared to the NHS England locality average of 0.12.

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 had planned, regular visits to care homes by GPs; we found that two GPs were allocated for each home to promote continuity of care. The practice had collaborated with the homes so that they had access to patient's electronic records whilst on-site which meant medical histories were available and that records were completed contemporaneously.
- 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.
- The practice had appointed a care coordinator to assist clinical staff in the practice to ensure frail elderly patients obtained the support and care necessary to reduce the risk of unplanned hospital admissions and to enable safe and timely discharge from hospital.
- The care coordinator liaised with the care homes to aid them with routine processes such as repeat prescriptions or medicine reviews.

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 provider had introduced specialist services to optimise care for patients with long term conditions; an example was diabetes care where patients with poor control were more intensively followed up; difficult to manage patients were referred for inclusion in the virtual clinic with secondary care specialists.
- There was routine referral to the local national diabetes prevention programme to educate patients about self-care and lifestyle.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

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.

Good

Are services responsive to people's needs?

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was working with their local GP practices to develop seven day availability for appointments as well as having 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.
- There was a high number of urgent appointments available each day which ensured patients whose circumstances made them vulnerable and those whose lives were less ordered were able to access appointments easily.

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 were working toward being a Dementia Friendly Practice so they can appropriately support patients and visitors living with dementia.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs and scored above average in the NHS Patient Survey. The GP patient survey results indicated that 91% of people were able to get an appointment to see or speak to someone the last time they tried which was better than CQC or national averages.

- There were express clinics on four mornings each week with a GP. This meant patients could book and attend and appointment within 72 hours.
- The percentage of respondents to the GP patient survey who gave a positive answer to "Generally, how easy is it to get through to someone at your GP surgery on the phone?" was 98% which was better than CQC of 70% and the national average of 71%.
- The practice had six 15 minute appointment per clinician each day to allow for those patients who may need extra time such patients who are older or who had complex needs.
- There were 'continuity' appointments slots reserved for patients who required a follow up appointment within a specific timeframe.
- 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 percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 95% which was better than CQC or national averages.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 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.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- 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.
- The practice was working with other GP practices in the locality to develop more integrated care services such as the Improved Access programme. This programme enabled patients to have access to appointments at other practices within the locality including evenings and weekends.

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. 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.
- 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. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- 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.

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. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- 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 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 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.

- The practice supported research for example; the practice nursing team were undertaking the research nursing work for two other GP practices so that their patients could be involved in a research programme. This meant the nurses were spending time at the other practices premises undertaking the research appointments which promoted integrated working.
- The practice was involved in 14 research studies between 2016 to 2018 and were awarded the 'Most Improved Introductory Site' in March 2018 by the NHS National Institute for Health Research.
- The practice employed a practice pharmacist who was able to undertake medicines optimisation, clinical protocol work and medicine reviews to release GP time.
- The practice participated in the One Care Limited, an organisation for primary care improvement and commissioning organisation and had accessed additional services for patients. An example of this was for musculoskeletal services which allowed patients who fit the referral criteria to have access to an assessment/consultation within five working days.
- 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.