Enderby Medical 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 May 2017 – 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 inspection at Enderby Medical Centre on 8th August 2018 as part of our inspection programme to ensure the improvements we had seen in May 2017 had been maintained. The practice was inspected in May 2016 and found to be inadequate in safe and well led and placed in special measures. When we inspected in May 2017 we found that it was good overall.

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 was organised and efficient with effective governance processes and was forward thinking on delivering care services in the future.
- The practice had a culture of raising awareness of local services available to patients and organised a health fair to promote all health care services in the area. Patients were able to have blood pressure readings, sign up for screening procedures or find out more information about local services available to them. The practice management had also developed a locality hub with four other practices and other agencies such as Blaby District Council, which held monthly meetings to promote awareness of the locality and offer support where required.

We saw one area of outstanding practice:

- The practice had purchased a machine to provide testing for inflammatory markers which are present when a patient is infected. This could be done at the practice to identify patients who would benefit from antibiotics from a small blood sample. The practice published a study on the effectiveness of this showing it reduced antibiotic prescribing and hospital admissions for respiratory tract infections.

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

- Review the buddy system for receiving test results and correspondence is effective.
- Review the process for summarising patient records to enable them to be completed in a timely manner.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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 manager adviser.

Background to Enderby Medical Centre

Enderby Medical Centre provides primary medical services to approximately 6,400 patients. The services are provided from Enderby Medical Centre, Shortridge Lane, Enderby, Leicestershire LE19 4LY.

The practice consists of four part time GP partners (two male and two female), one full time physicians associate, one full time nurse practitioner, two part time pharmacists, two part time practice nurses and one part time health care assistant. The clinicians are supported by a practice manager, an assistant practice manager and a team of receptionists and administration staff.

Enderby Medical Centre was registered to provide the following regulated activity from the location: Treatment of disease, disorder or injury, Diagnostic and screening procedures, Family planning, Maternity and midwifery services and surgical procedures.

The practice has more patients under the age of 65 than the national average and less patients 65 years or over than the national average. Deprivation levels in the area were the least deprived in the country.

The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG). The practice has a General Medical Services contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is open between 8am and 6.30pm Monday to Friday and offered extended hours on Wednesday from 7.15am to 8am and 6.30pm to 7.15pm. The practice offers appointments between 8.15am and 5.45pm in the practice. The practice also offered telephone consultations and home visits for patients who were housebound.

When the practice is closed patients are asked to contacted NHS 111 for out-of-hours GP care.

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. The practice had a named lead for both adult and child safeguarding. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The practice held registers for patients who were vulnerable and these patients were discussed at safeguarding meetings with other involved healthcare services.
- Chaperones were available to patients when required. 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.
- Appropriate staff checks were carried out at the time of recruitment and on an ongoing process. The practice had induction packs and checklists for new staff members tailored to their role.
- There was an effective system for temporary staff including recruitment checks and induction information. Temporary staff were supported by the duty doctor.
- There was an effective system to manage infection prevention and control. There was a named lead for infection control who carried out annual audits and follow up audits every six months.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice would use locum doctors when required.
- We found the buddy system in place to cover test results and correspondence to not be effective. On the day of inspection we saw test results and correspondence which had not been actioned in a timely manner.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice had desktop aids for all staff to recognise any emergency symptoms.
- 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.
- During the inspection we saw evidence of one receptionist recognising and responding to a patient who was showing signs of deterioration.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. During changes to staff and recruitment periods the practice assessed which tasks were priorities and put systems in place to ensure patients safety was maintained for any tasks which were not being completed at that time.

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 utilised the Single Point of Access (SPA) scheme in Leicestershire which coordinates referrals for community services across the area. This enabled the practice to refer to one place for advice on referrals and matching patients' needs to the right service such as community nursing, intermediate care, therapy services and other specialised therapy services available in the area.

Good

Are services safe?

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The practice held meetings with other health professionals and agencies to ensure they were involved in patients care when necessary.
- 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.
- The practice adhered to local and national prescribing guidance when prescribing which was supported by the Medicines Optimisation Team at East Leicestershire and Rutland Clinical Commissioning Group (CCG).
- 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 taken action to support good antimicrobial stewardship in line with local and national guidance. Antibiotic prescribing was in line with local and national averages.
- 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 where clinicians also looked at compliance and effectiveness of treatment.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues. All risk assessments were reviewed annually.
- 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 told us that leaders and managers supported them when they did so.
- The practice had a structured system for reviewing and investigating when things when wrong and were completed in a timely manner.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Full reviews of incidents were discussed at regular clinical governance meetings with the full practice team.
- The practice acted on and learned from a range of 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.

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 supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice had purchased equipment to test patient's inflammatory markers when presenting to the surgery with suspected infections. The clinicians had published a study in the Journal of General Practice to show that by having this machine, antibiotic prescribing would decrease and emergency department admissions would decrease in patients with respiratory tract infections. The practice routinely used this when assessing patients with suspected infections and reported an increase in patient satisfaction and a decrease in unnecessary antibiotic prescribing.

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 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. Clinicians would address if any additional needs were required for the patient and pass onto the single point of access service.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice pharmacist reviewed patient's medication for polypharmacy, compliance with medicines and to ensure patients were being treated effectively for their condition.
- Longer appointments were offered for elderly patients or patients with multiple conditions to discuss all needs and ensure patients were involved in decision about their care.
- The practice nursing team offered a frailty and dementia clinic, supported by GPs to ensure patients' needs were monitored.

People with long-term conditions:

- The practice held a chronic disease management clinic with nurses for patients with long term conditions. Structured annual reviews were conducted to check health and medicine needs were being met with best guidance templates and recorded on patient's records.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- GP's followed up patients who had received treatment in hospital or through out-of-hours services.
- The practice performance on quality indicators for long term conditions were above local and national averages. They had performed significantly above local and national averages in managing blood pressure readings in patients with hypertension.

Families, children and young people:

- Childhood immunisation uptake rates were consistently higher than the target percentage of 90% or above.
- The practice offered children appointments on the day or would refer to the duty doctor if there were no appointments left to ensure the child is dealt with on the day.
- 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):

Good

Are services effective?

- The practice's uptake for cervical screening was 81%, which was above the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- 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.
- The practice offered well man or well woman clinics to assess patients' health if they have no long-term conditions.

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. GP's would conduct weekly visits to patients at home if this was the chosen place of care.
- The practice held a register of patients living in vulnerable circumstances including travellers, those receiving end of life care and people with a learning disability.
- The practice offered annual health checks to patients with a learning disability

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 referrals 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 and could access the CRISIS team if urgent support was required. The practice ensured these patients were followed up by the community health team.
- 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.
- Patients with dementia had annual checkups and medication reviews with the dementia lead GP.
- The practice was a dementia friendly practice where all staff had been through the dementia friends training and were aware of signs and symptoms of developing dementia.
- The practice offered counselling sessions and cognitive behavioural therapy sessions in house for patients when required.
- The practices performance on quality indicators for mental health was consistently above local and national averages. The practice identified this was due to having a mental health worker who reviewed and supported patients with mental health needs.
- The practice referred patients to an in-house drug and alcohol advisor to help support patients with alcohol and drug dependency.

Monitoring care and treatment

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

- The practice had obtained 100% of the QOF score with all indicators being comparable and some showing significant positive variation, to local and national averages. The practice reported that all staff were involved in obtaining QOF information and the practice had a lead nurse to manage the scheme.
- Overall exception rate was in line with local or national averages. The practice reported a process for inviting patients to visit the practice primarily via telephone call before sending invite letters. If after three attempts the patient did not attend the surgery they were excepted from the data which we saw evidence of on the day of inspection.
- 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.

Good

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and 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. Staff reported the practice management had allowed extra learning time if they had requested it.
- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. We saw evidence of additional training offered for practice staff when requested.
- The practice provided staff with ongoing support. There was an induction programme and checklist for new staff. This included training required and progress meetings within the first months. There were induction packs for all roles within the practice which we saw completed for new starters.
- 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 referred patients to community services and local agencies through the single point of access scheme to ensure patients get the correct support available in the local area. 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.
- 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.
- 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 management had been involved in the development of North Blaby district hub with four local practices and the Blaby District Council to share information on services available in the local communities. The hub met regularly and worked together to identify issues or gaps in the local care provision, share knowledge and ideas on how to improve care services in the area.

Helping patients to live healthier lives

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

- The practice identified patients who may need extra support and directed them to relevant services through the single point of access scheme. 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.
- The practice organised a health fair in the village to promote health and included information from a range of services such as screening information, alternative therapies and care services available in the area. The practice also offered health checks at the fair which could then be followed up by GP's. This health fair increased referrals to mental health therapies, screening appointments were booked and uptake increased, and patients who had opportunistic blood pressure monitoring were invited into the surgery for further investigation.

Consent to care and treatment

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

Good

Are services effective?

- 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 holds a register of patients with a deprivation of liberty restrain in place and all clinicians had been trained in deprivation of liberty and mental capacity act.
- 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 comparable with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- The practice had no hearing loop in place by recommendation of a specialist due to the layout of the room and confidentiality issues. However, the practice could demonstrate how the communicate with patients who had hearing impairments.
- 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 practice had a carers champion who had produced a pack of useful information. Carers were offered annual health checks and annual influenza vaccinations.
- The practices GP patient survey results were comparable with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- 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.
- Longer appointments were available for patients with multiple conditions or vulnerable patients to enable more in-depth discussions.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. Consultation rooms were across two floors of the practice with no lift access however for patients with reduced mobility clinicians could use different rooms downstairs.
- 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 over 75 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. Vaccinations and medication/long term condition reviews were available for housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

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. We saw evidence that children and young peoples who had attended accident and emergency (A&E) were reviewed and monitored.
- 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. Extended hours appointments were available on Wednesdays.
- The practice offered sexual health and contraceptive clinics which included coil and implant fittings.
- Patients were offered electronic prescriptions and online appointment booking.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. The practice liaised with a community nurse who worked with travellers and offered support and education to them when required.
- The practice had a GP lead for patients with a learning disability who offered annual reviews.
- The practice cared for patients with learning disabilities in a local residential home where the lead GP and pharmacist would conduct 6 monthly reviews of patients to review medicines, treatment regimes and care plans.

Good

Are services responsive to people's needs?

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. The practice could demonstrate supporting these patients through secondary care appointments including operations.

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.
- Doctors committed to offering extended hours for elderly patients to conduct assessments of patient's mental health and dementia. Patients would then be sent for dementia screening and referred to the Alzheimer's Society for interim support.
- The practice held GP led dedicated mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients with dementia had annual reviews and a mental health worker offered ongoing support.
- The practice utilised the dementia toolkit to help assess cognition including new patients at the practice or in care homes. They also used the 'dear doctor' scheme to encourage patients and families to identify of any concerns or extra needs that were required.

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.
- The practice had a team of allied health professionals such physicians associate and pharmacists who were able to conduct appointments with patients. These were always supported by a duty doctor for any urgent needs or prescribing that resulted from consultations. The practice was planning for more professionals to join the team including a paramedic to offer more varied appointments.
- The practice was a training practice with doctors in differing stages of their training who could offer some appointments to patients with support from the duty doctor.
- 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 consistently above local and national averages for questions relating to access to care and treatment. The results were significantly higher for patients being able to access the practice on the telephone, than local and national average.
- The practice conducted its own feedback survey for access due to some negative comments. The practice found when conducting their own feedback following the addition of the extra health professional appointments, patients were happy with appointment availability.

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 performed a full investigation into every complaint which involved all staff who were involved in the incident.
- The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice discussed complaints at team meetings with all practice staff to share learning.
- All complaints were responded to in a timely manner and included an apology to the complainant in line with the duty of candour.

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.
- The practice planned for future developments and were in the process of employing further specialised health professionals to give their patients quality care based on their specific health care needs.

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.

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. The practice was committed to offering patients specialised health and social care needs for all aspects of patient care and treatment.
- 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. We saw evidence of additional training for staff when requested.
- Staff were supported to meet the requirements of professional revalidation where necessary. Clinicians had protected learning time to ensure all training could be completed.
- 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. If support was needed management staff would assist in all areas of the practice if required.
- 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 co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The practice had named leads for different aspects of the practice including different long-term conditions and patient groups.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear 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.
- 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.
- The practice had a backlog of unsummarised notes due to staff turnover. The practice management were aware of this backlog and had put systems in place to ensure patients records were stored so that they could be accessed if needed urgently. They also ensured that any patients who had moved into the service, had been identified for safeguarding concerns or urgent medical information such as allergies had been highlighted. The practice had a schedule of how to clear the backlog when staffing capacity increased including completing children and young peoples first.

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.
- Changes were discussed with all practice staff during monthly meetings prior to being implemented.
- 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 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.
- The practice identified a lack of engagement with patients who did not routinely visit the practice. They organised a health fair in the community to promote awareness of services provided by the practice as well as an opportunity to have health assessed such as blood pressure monitoring conducted. There was evidence on the day of patients being referred to agencies for support, patients who booked screening appointments and patients who were identified as having high blood pressure and subsequently followed up in the GP surgery.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- 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.
- The practice management had developed a hub with four other local practices and other agencies such as Blaby District Council, to promote awareness of the locality and offer support where required.

Please refer to the evidence tables for further information.