Birbeck Medical Group

Inspection report

Penrith Health Centre
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous rating June 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Birbeck Medical Group on 5 July 2018 as part of our inspection programme.

At this inspection we found:

•Recommendations made during the last CQC inspection had been acted on and improvements had been made.

•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.

•The practice made good use of social prescribing, and had close links with a number of organisations in the local community that promoted healthy living.

•There was a nurse practitioner who specialised in sexual health. The practice provided sexual health services for their own patients as well as other practices in the area.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw two areas of outstanding practice:

•The practice held weekly learning disability clinics and patients attending these clinics were encouraged to contribute to their own action plan which they were then given to keep and refer to. These were one-to-one sessions to review patient's health and wellbeing. The practice had a higher than average number of patients reporting a learning disability (3.8% compared to a local average of 2.9% and national average of 3.1%)

•Nurses at the practice had been trained in insulin initiation so that they could begin treatment for patients in low-risk diabetes cases. Nurses did home visits to assess patients' insulin, and they worked closely with other clinicians, such as podiatrists and secondary care consultants. So far, 14 patients had been initiated on insulin by nurses at the practice, saving them from having to access secondary care for this service.

The areas where the provider should make improvements are:

•Where staff have not had Disclosure and Barring Service (DBS) checks a risk assessment should be carried out detailing why one has not been deemed necessary.

•Continue to request that the fire risk assessment of the premises is updated.

•Continue to request that improvements are carried out to the premises to help patients who may require additional assistance.

•Continue to maintain an up-to-date staff training matrix to assist in ensuring staff have completed all mandatory training requirements and updates.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

Older people	Good
People with long-term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a practice manager specialist advisor.

Background to Birbeck Medical Group

Birbeck Medical Group is registered with the Care Quality Commission to provide primary care services. The practice provides services to over 14,600 patients from the following location: Penrith Health Centre, Bridge Lane, Penrith, CA11 8HW. We visited this address as part of the inspection. The practice is part of NHS North Cumbria Clinical Commissioning Group (CCG).

Deprivation indicators place this practice in an area with a score of eight out of ten. A lower number means an area is more deprived. People living in more deprived areas tend to have greater need for health services. This practice had lower levels of deprivation when compared to the local CCG and England averages. The practice has greater numbers of patients aged 65 and over compared to CCG and England averages.

The practice occupies a purpose built building which it shares with another practice. Consultation rooms and patient areas are on the ground floor. There is car parking directly outside, with disabled bays.

The practice team comprises 10 GPs (five partners, five salaried GPs), seven practice nurses, two advanced nurse practitioners, three healthcare assistants, a prescribing pharmacist, and a team of management and administrative staff.

When the practice is closed patients are directed to the NHS 111 service, with out of hours services being provided by Cumbria Health on Call (CHoC). This information is also available on the practices' website and in the practice leaflet.

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 held monthly safeguarding meetings with health professionals including midwifes, the local minor injury department and health visitors. There were two lead GPs, a lead practice nurse and an administration lead who was a point of contact with local schools.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) However, some staff at the practice who did not have direct patient contact had not received a DBS check, and no risk assessment had been completed to document the reasons why it was deemed unnecessary for them to have one.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, 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.
- However, we saw that no fire risk assessment had been carried out on the premises since June 2016. We saw evidence that the provider had contacted the owners of the premises to request that this risk assessment be updated.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

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

Good

Are services safe?

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

(Please note: Any Quality and Outcomes Framework (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 needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff 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 were frail or may have been 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.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital and 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.

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.
- Nurses at the practice had been trained in insulin initiation so that they could begin treatment for patients in low-risk diabetes cases. Nurses did home visits to assess patients' insulin, and they worked closely with other clinicians, such as podiatrists and secondary care consultants. So far, 14 patients had been initiated on insulin by nurses at the practice, saving them from having to access secondary care for this service. Nurses held a weekly meeting with GPs to discuss diabetic patients. Patients were also given copies of their care plans to take away.
- 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 was proactive in ensuring patients had appropriate reviews for asthma and had scored significantly higher than local and national averages in doing so.
- 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.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates were well above the target percentage of 90% for immunisations.
- 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.

Good

Are services effective?

- The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was in line with local and national.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- 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 have made 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 held weekly learning disability clinics and patients attending these clinics were encouraged to contribute to their own action plan which they were then given to keep and refer to. These were one-to-one sessions to review patient's health and wellbeing. The practice had a higher than average number of patients reporting a learning disability (3.8% compared to a local average of 2.9% and national average of 3.1%).
- 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.
- The number of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the previous 12 months was comparable to the national average.
- The number of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the previous 12 months was above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- 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.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives, such as the clinical commissioning group's (CCG) Quality Improvement Scheme.

- The practice had achieved 558 of the total number of 559 QOF points available, compared to the CCG average of 554 and the national average of 539. Overall the practice exception reporting rate was slightly higher than the local and national averages at 7.2% (CCG average 5.4%, national average 5.7%). The practice was aware of this and was able to show us that they had taken steps to reduce it.
- The practice used information about care and treatment to make improvements.
- The practice were involved in local pilot schemes, for example a musculo-skeletal project which offered patients an appointment with a specialist practitioner. This scheme has now been extended across North Cumbria.

Effective staffing

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

Good

Are services effective?

- On the day of inspection we saw that while the practice kept records of staff training they were not able to show when asked that staff had completed all mandatory training as required. Records did not show that training in areas such as safeguarding children and adults had been completed to an appropriate level within the past three years. However, following the inspection the practice supplied evidence to show that staff had completed mandatory training, including training for safeguarding adults and children at an appropriate level for their role, and had updated their records to show this.
- 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 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 practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams 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 had 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.
- The practice made good use of social prescribing, and had close links with a number of organisations in the local community that promoted healthy living. For example, they offered exercise on prescription to patients in conjunction with a local leisure centre. The practice had worked with the leisure centre to start the programme. Data we saw showed that so far the practice had referred 99 patients, the highest number in the local area.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Patients could be referred to a weight management programme to assist weight loss.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking and tackling obesity campaigns.

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.

Good

Are services effective?

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's National GP patient survey results were generally in line with local and national averages for questions relating to kindness, respect and compassion. The survey showed a significant positive variation for questions relating to how well nurses listened to patients, and how good nurses were at treating patients with care and concern.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's national GP patient survey results were in line 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 GP 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. However, there was no system whereby people who struggled to access the practice could call for help, nor was there an alarm in the disabled toilet for patients to call for assistance if required. The practice told us they would take this matter up with the owners of the building, and following the inspection we saw evidence that these issues had been raised.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Self help and self-referral forms were available on the practice website.

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.

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.
- The practice offered exercise on prescription. They had worked with a local leisure centre to set up the programme. A member of staff from the leisure centre came to the practice to assess patients for the programme, and there was a dedicated member of the practice's reception team who arranged the consultations with the leisure centre staff. Data we saw showed that so far the practice had referred 99 patients to the programme, the highest number in the local area.
- They also offered some patients with diabetes home visits to assess their insulin. They had close links to other professionals involved in the care of diabetic patients, for example the secondary care consultants and podiatrists. Diabetic patients were given their own care plans to take home.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- 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 opening hours appointments and repeat prescriptions were available to order online.
- The practice held extended access two evenings per week until 8.30pm, where patients could access a range of GP, Health Care, Sexual Health and Pharmacist services.
- The practice had a designated direct line to the secretarial team for patients to make referral enquires.
- There was a nurse practitioner who specialised in women's health and sexual health and was able to offer

Good

Are services responsive to people's needs?

level two screening and coil and implant fitting. The practice also provided this service for other practices in the area, thereby saving patients in the Eden area a journey to Carlisle to access sexual health services.
- The practice used a text messaging service for appointment reminders, information on the service such as the practice newsletter, and also to enable patients to give direct feedback.

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 nurse at the practice who was the lead for patients with learning difficulties. They held weekly learning disability clinics and patients attending these clinics were encouraged to contribute to their own action plan which they were then given to keep and refer to.

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 held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- There was a nurse at the practice who was the lead for mental health. They held weekly meetings with the community mental health team and monthly meetings with the local memory service to discuss patients. They also carried out dementia reviews in patients' own homes.

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 commissioned an access audit with recommendations to improve timely access to appointments and minimise did not attend rates. The practice had implemented these suggestions including initial phone consultation with a GP and a further face-to-face consultation if required with the most appropriate clinician. Receptionists were given extra training in signposting. Feedback we received on patient comment cards was mostly positive about access to appointments.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practices GP patient survey results were in line with local and national averages for questions relating to access to care and treatment. A practice survey of 49 respondents showed an improvement since the last inspection in 2015 in areas such as length of waiting time, convenience of appointment and able to see their clinician of choice, with most patients being satisfied.

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 as good for providing a well-led service.

Leadership capacity and capability

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

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

Vision and strategy

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

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

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on any staff behaviour and performance which was 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.
- 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.
- Anniversary parties were held for long-serving staff. Staff we spoke to told us they valued this recognition of their service.

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
- 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.

- 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.

Good

Are services well-led?

- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored. The practice participated in local quality improvement schemes and monitored their performance through this.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. For instance the practice could demonstrate continued reduction in hypnotics and antibiotic prescribing, and had identified an increase in anti-depressant prescribing as an area to target for 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.

Please refer to the evidence tables for further information.