Aylestone Surgery

Inspection report

Aylestone 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. (The practice was previously inspected 26 July 2017 and rated good overall)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Aylestone Surgery on 11 June 2018.The practice is part of a partnership (Leicester Medical Group) with nearby practice in Thurmaston (Thurmaston Health Centre). We identified serious concerns at the Thurmaston practice during recent inspection and therefore we inspected Aylestone Surgery to ensure the same risks did not exist.

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.
- Feedback from Care Quality Commission(CQC) comment cards that we received and NHS choices reviews suggested that patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- We saw evidence that the practice sought feedback from staff and patients, which it acted on. For example, the practice had employed a long-term female locum GP as requested by patients.
- The practice was located in a modern purpose-built building which provided good facilities and was well equipped to treat patients and meet their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Continue to identify the number of carers registered at the practice so they can be offered further help and support.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief 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 and a second CQC inspector.

Background to Aylestone Surgery

Aylestone Surgery is located in Aylestone Health Centre which is a modern purpose built building with a lift and parking, including disabled parking. It has automatic doors, a hearing loop, an on-site wheelchair, and on-screen announcement of appointments. The practice provides primary medical services under a General Medical Services contract to around 3000 patients in a residential area of Leicester. The practice's services are commissioned by the Leicester City Clinical Commissioning Group (LCCCG).

There is one senior male GP based at Aylestone who provides seven clinical sessions each week. The practice employs one female long-term GP locum to provide four sessions each week There is a female practice nurse who is also the practice manager and a female health care assistant who works part-time.

The practice is part of the Leicester Medical Group which is a partnership operating two separate locations, one in Aylestone and one in Thurmaston (Thurmaston Health Centre). The GP and the practice manager explained that although they were a partnership with the practice at Thurmaston, they operated separately. The GP at Thurmaston (who was also the registered manager) had not worked at Aylestone Surgery for a number of years. At the time of the inspection the practice had submitted application to remove the registered manager so that registration with the CQC reflected how the practice was currently being run.

The practice is open between 8am and 6.30pm Monday to Friday. There are no routine appointments on Thursday afternoon after 1pm. The phone is redirected to Prime Care (a manned external answering service) who are able to contact the GP in an emergency or advise the patient to attend one of the healthcare hubs in Leicester. There is another telephone line for healthcare professionals and social services which is answered during this time.

Out of hours services are provided by Derbyshire Health United (DHU) via the 111 telephone number. Patients are directed to the correct numbers if they phone the surgery when it is closed.

Patients registered with Leicester City practices can also access (initially by telephone) three 'Healthcare Hubs' (located at health centres/GP practices) during evenings and weekends.

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.
- 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. For example, locum GP packs were available.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice with the help of the PPG carried out a mock incident, testing out the emergency response 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. There was written guidance available in the practice and on the clinical system.
- 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. We reviewed a sample of urgent two-week referrals and saw that they were appropriate and contained relevant information and referral templates were fully populated.

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 had reviewed its antibiotic prescribing and had acted to support good antimicrobial stewardship in line with local and national guidance. CCG data shared by the practice showed that they were meeting targets set by the CCG. The practice told us that they were third best out of a total of 63 practices within the CCG for cost effective prescribing.
- 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.
- The practice had a protocol for uncollected prescriptions. All prescriptions not collected after one month from date of issue were reviewed and the deleted from the computer where appropriate. However, the practice kept prescriptions for patients

prescribed medicines for their mental health in a separate (red) folder and these were reviewed every two weeks. All patients on repeat mental health medicines received a call from the GP after three months and a review was carried out if required.

Track record on safety

The practice had a good track record on safety.

- There was evidence that actions had been taken to reduce risks in relation to safety issues. The practice could not provide evidence of a fire risk assessment. However, we saw that the risk assessment had been summarised and action taken to reduce risks.
- 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. They received support from management 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 acted to improve safety in the practice. An example we looked at demonstrated that the practice had investigated the incident, responded to the patient affected appropriately, made improvements to practice and shared learning with staff.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. The practice had carried out an audit following receipt of an alert and we saw evidence of appropriate follow up.

Please refer to the Evidence Tables for further information.

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 needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. We saw evidence that the practice followed appropriate guidelines and pathways for making referrals. Guidelines such as NICE were available to the GPs on their desktops.

- 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.
- The GP had developed a RAG (Red, Amber, Green) rated matrix system that allowed them to monitor the most vulnerable 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 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.
- 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. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice referred patients to the CCGs Clinical Response Team to ensure those that were likely to attend accident and emergency received a home visit from the team. This was a CCG initiative to reduce unplanned admission to hospital.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice provided in-house chronic disease management for all patients 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.
- 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 one of the lowest for accident and emergency attendances.
- The practice applied 'special notes' on the records of patients with long term conditions to allow communication with external organisations such as out of hours services in the event they were involved in the care of these patients.
- The practice could 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 for the vaccines given were in line with the target percentage of 90% or above.
- 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. For example, pertussis vaccination was offered.
- The practice had on-site mid-wife clinics.
- The practice had arrangements to follow up patients that failed attend appointments following an appointment in secondary care or for immunisation.

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

Are services effective?

- The most recent uptake for cervical screening which was 89%, this was above the 80% coverage target for the national screening programme. This was the highest uptake within the CCG.
- The practices' uptake for breast and bowel cancer screening was above local CCG and national averages. The practice told us that they had piloted a programme with the CCG to write to patients who did not attend their screening appointment. The practice was hoping for further improvement but had not received the latest results from the CCG.
- The practice had systems in place 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 staff were able to refer any vulnerable patients to the Care Navigators (based at the CCG) should they require social care support (following consent of patients).
- The practice held a register of patients living in vulnerable circumstances including 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 severe mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long term medication. All patients on repeat mental health medicines received a call from the GP after three months and a review was carried out if required.
- 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.
- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is slightly below the local CCG average of 85% and the national average of 84%.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was similar to the CCG average of 93% and 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, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is above the CCG average of 93% and the national average of 91%.
- 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 held weekly onsite clinics with a mental health facilitator. This was a CCG initiative.
- 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. We saw three audits which demonstrated quality improvement.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 96%. The overall exception reporting rate was 3% which was below local the national average of 6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

Effective staffing

Are services effective?

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, appraisals, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate.

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. They shared information and liaised, with community services, social services and carers for housebound patients.
- 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 and patients at risk of developing a long-term condition. The GP had developed their own risk matrix to enable them to manage and support vulnerable patients.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The practice referred patients to social workers and care navigators.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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.

Please refer to the Evidence Tables for further information.

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. There was a prayer room available.
- The practice gave patients timely support and information.
- The GP told us that they had attended funerals of several patients and the families of the deceased were very grateful.
- A staff member had been diagnosed with a medical condition and the practice had provided training and advice on how to treat their condition. The practice also informed and trained all staff so that they were able to manage the condition if required. This was supported by the development of a protocol.

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 had identified 26 patients (0.8%) if the list size and had made arrangements to improve.

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. We saw a documented example of this.

Please refer to the Evidence Tables for further information.

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 and online (request for) appointments were available which supported patients who were unable to attend the practice during normal working hours.
- The practice had employed a regular female locum GP and this had increased GP capacity by 22%.
- The service was located in purpose-built premises and enabled easy access for those with a disability.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice referred patients to the Clinical Response Team (based at the CCG) if they were likely to be admitted to the hospital.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice proactively referred to health navigators (a CCG initiative) to instigate social care support.
- The practice had introduced a daily 8.50am appointment slot to review any patients the GP felt they needed to follow up or refer as appropriate. This was intended to reduce admission to secondary care and generally patients with conditions such as asthma, COPD as well as other long-term conditions were followed up.

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.
- The practice held onsite health visitor clinics alongside the nurse's childhood immunisation clinic to allow easy communication of any issues.
- The premises were purpose built and there was baby change facilities and a dedicated room for breastfeeding.

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 offered meningitis C vaccine to all students in line with national guidelines.
- NHS health checks were offered to all eligible patients.
- Online and telephone consultations were offered.

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.
- Health checks were offered to patients with a learning disability.

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.
- Following consent, the practice referred patients with a learning disability to a care navigator for social care support (if the practice had concerns).
- The GP often added notes to patient records to make administration staff aware that these patients were able to see a GP on the same day. These were usually vulnerable patients with for example, mental health issues and depression.
- We saw evidence of a referral made by the practice following concerns staff had during a home visit. The practice liaised with the social services and as a result the patients package of care had been reviewed.

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 monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months (2016 to 2017) was 78%. This was comparable to the local and national averages.
- Performance for overall mental health related indicators for 2016/17 was comparable to other practices nationally.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Feedback we received we positive about access to appointments.
- Patient feedback through the national GP survey was above local and national averages for questions related to access to appointments.

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 had not received any written complaints in the last 12 months but had documented two verbal complaints/grumbles. We saw evidence that they were responded to appropriately and learning was shared with staff in team meetings.

Please refer to the Evidence Tables for further information.

Are services well-led?

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

Leadership capacity and capability

The practice was led by the GP and the practice manager who was also the practice nurse. They were able to demonstrate that they had the capacity and skills to deliver high-quality, sustainable care.

- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them working with the CCG where relevant.
- The practice management 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. Staff members were supported enabled to take on responsibilities and had access to further training.

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 nurse was on the board of the local CCG as a nurse representative and this further facilitated the practice to align its strategy with local priorities.

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. Staff members we spoke with were aware of their roles, received appropriate training and took pride in their roles. The practice took on feedback from staff and made changes to improve service.
- The practice focused on the needs of patients. For example, the practice worked with the CCG to deliver on local proprieties and ensured vulnerable patients were being managed effectively.
- Management acted on behaviour and performance consistent 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 needed. 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 management.

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

Are services well-led?

- Practice management had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the practice ensured that they reviewed patients on the QOF register for asthma before September /October. This was to ensure these patients had the relevant treatment before winter when their conditions were likely to exacerbate.
- The practice ensured that all QOF follow up were completed by December so that they could focus on hard to reach patients. We were told that patients with diabetes were one of the hard to reach groups.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their prescribing and referral decisions. Practice management 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. It had held a mock emergency incident with the help of the PPG.
- Administration staff were able to override the appointment system to add a patient that they have recognised as not being well even if patients had not asked.

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 patient group.
- 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. For example, the GP had developed a matrix system to better manage vulnerable patients.
- 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.
- The practice had responded to patient surveys and had made changes where appropriate.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The practice provided training for undergraduate doctors and nurses. The practice planned to become a training practice for qualified doctors to become GPs.
- Learning was shared and used to make improvements.
- The practice had recently employed a pharmacist whose role would include focussing on medicines management such as medication reviews.
- The GP and the practice nurse undertook continuous learning and development to improve the quality of care provided. For example, the practice nurse had received training in insulin initiation and the GP had attended training atrial fibrillation (irregular heartbeat that can lead to heart related complications).
- The GP had developed a RAG (Red, Amber, Green) rated matrix system that allowed them to monitor the most vulnerable patients. The list consisted of patients from the vulnerable children and adult register, mental health

register, house bound register as well as other QOF indicators. Searches were carried out monthly and patients were added or taken off the matrix as appropriate. The system allowed the GP to view and evaluate who had been reviewed and to schedule further reviews.

Please refer to the Evidence Tables for further information.