Westfield 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 inspection 23 August 2017 – Requires improvement.)

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 Westfield Medical Centre on 23 August 2017. The practice was rated as requires improvement in the key questions of safe and well led. The full comprehensive report on the August 2017 inspection can be found by selecting the 'all reports' link for Westfield Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 29 May 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach of regulations that we identified at our previous inspection on 23 August 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as Good.

At this inspection we found:

- The practice had clear, organised and effective 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 provider held an annual away day which was attended by the partners at Westfield Medical Centre and those of their sister practice. Clinical priorities, objectives and business plans were developed which set out the priorities of the organisation for the next 12 months. An action plan developed from the meeting was reviewed weekly by the partners and cascaded to the staff team.
- The practice reviewed the effectiveness and appropriateness of the care it provided within structured and documented meetings. 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 comment cards reflected that the majority of patients found the appointment system easy to use and they were able to access care when they needed it.
- A comprehensive system for the reporting, recording and reviewing of significant events was in place. These were routinely shared with the staff team.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice had responded and actioned the previous breach of regulations and issues noted in the report of August 2017.

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

- The provider should continue to review and take steps to improve the uptake of bowel and breast screening by patients registered with the practice.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Westfield Medical Centre

Westfield Medical Centre provides services for 4,119 patients and is situated on the first floor of The Reginald Centre, 263 Chapeltown Road, Leeds, LS7 3EX, West Yorkshire. There are fully accessible facilities and services are reached via the stairs or a lift. There is car parking available and the centre is accessible by bus. The surgery is situated within a large health centre which also hosts other community services including a pharmacy, a library and a café.

The website address is www.westfieldmedicalcentre.co.uk.

Westfield Medical Centre is situated within the Leeds Clinical Commissioning Group (CCG) and provides primary medical services under the terms of a personal medical services (PMS) contract. This is a contract between general practices and primary care organisations for delivering services to the local community.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, surgical procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

There is a higher than average number of patients aged between birth and 39 years old when compared to the national average. Only approximately 8% of the practice population is aged 65 years and over compared to the national average of 17% and the CCG average of 16%.

The National General Practice Profile states that 27% of the practice population is from an Asian background with a further 26% of the population originating from a black ethnic background. 10% of the practice population are from mixed or non-white ethnic groups.

There are two GP partners, (one male, one female) and a business partner. We were told the male GP partner does not often work at the practice. The practice is also staffed by two female salaried GPs, two part time practice nurses, and two health care assistants (HCAs), all of whom are female. The practice is also supported by a pharmacist from the CCG.

The clinical team are supported by a business support manager, an office manager and a team of administrative staff.

The lead GP was a GP trainer and the practice was able to offer training opportunities to student GPs.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

Westfield Medical Centre reception is open between 8.00am and 6.30pm Monday to Friday and appointments were available from 8.30am to 6pm daily at this location. Extended hours access was available at the practice every Tuesday between 6.30pm and 7.30pm.

The practice works closely with other practices in the locality to provide additional out of hours appointments.

Allocated appointments are available Monday to Thursday between 6pm and 8pm and on a Saturday morning between 9am and 12pm at nearby locations. A range of appointments are offered with a pharmacist, GP, practice nurse, and a HCA.

Out of Hours, patients are advised of the NHS 111 service.

During our inspection we saw that the provider was displaying the previously awarded ratings in the practice and on their website.

Good

Are services safe?

We rated the practice as good for providing safe services.

At the inspection on 23 August 2017 we rated the practice as requires improvement for providing safe services. A breach of the regulations of the Health and Social Care Act 2008 was found which included a number of safety issues. At this inspection on 29 May 2018, we saw that actions had been taken to resolve those concerns.

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. For example, all GPs were trained to safeguarding children level three. 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, recorded their involvement in the patient notes 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.
- We reviewed the personnel files of three members of staff and found that the practice had improved their systems to ensure the safe recruitment of staff. We saw that appropriate staff checks were undertaken at the time of recruitment and on an ongoing basis.
- There was an improved system in place to manage infection prevention and control (IPC). Previous issues which included the replacement of privacy curtains in line with national patient safety guidance and the labelling of sharps bins had been resolved.
- 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. We saw that additional clinics had been offered during holiday periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. Antibiotic prescribing was lower than CCG and national averages.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. We saw that patients were invited for timely medicines reviews and that records were up to date and current. Patient feedback showed they were involved in regular reviews of their medicines.
- Patient records reflected those who were prescribed DMARDS (Disease-modifying anti-rheumatic drugs). This highlighted to the team the monitoring requirements of this complex group of medicines and ensured that tests and individual requirements were closely monitored.

Track record on safety

The practice had improved their ability to offer a safe service.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity, complaints and significant events. 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 clearly understood their duty to raise concerns and report incidents and near misses. We were told that leaders and managers supported them when they did so.
- There were improved systems for reviewing and investigating when things went wrong, which included comprehensive documentation of the event, actions and lessons learned. We reviewed meeting notes and spoke with staff and were assured that the practice learned and shared these lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

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

Effective needs assessment, care and treatment

The practice partners and managers met regularly and communicated closely which ensured that clinicians were kept 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.
- We saw that the practice utilised electronic patient records to identify patient needs, improve treatment and to support patients' independence.
- Staff used appropriate methods 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.
- The practice were working closely with other local practices and voluntary organisations to offer a monthly patient education session. During the evening event, GPs from the practice would deliver a talk which related to the joint priorities of the locality. The talks had included information about diabetes, blood pressure and stroke. Up to 70 patients had attended the talks and suggestions had been put forward by patients for further sessions.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice held a register of patients aged 65 and over who were living with moderate or severe frailty and these patients were allocated a named GP. Those identified as being frail were invited for a six monthly clinical review which included a review of their 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.
- Multi-disciplinary Gold Standard meetings were held monthly to review the needs of those patients who were vulnerable or required end of life support.
- The practice held multi-disciplinary meetings with the community nursing team and was involved in the roll out of the primary care home model. This model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice were using the 'Year of Care' model to drive improvement in long term conditions such as Diabetes. This included the development of effective care plans for patients and promoting self-care in health and wellbeing.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate. We saw that 100% of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more were appropriately treated with anti-coagulation drug therapy.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes and chronic obstructive pulmonary disease. They were able to use the specialist expertise of the GP partners at their sister

practice to assist them to review complex patients. We saw that staff who were responsible for the management of patients with long term conditions had received specific training.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to the target percentage of 90%. The practice were reviewing children who had not been presented for their vaccinations, following a measles outbreak in the county.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Appointments were available after school hours.

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

- The practice's uptake for cervical screening was 78%, which was in line with the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was below the CCG and national average. We were told of a comprehensive system which was in place to ensure that patients were recalled for screening.
- 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 to 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 reviewed monthly with members of the multi-disciplinary team including the palliative care team and more often within the clinical team meetings. Care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those who were frail, homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients could be referred to a wellbeing co-ordinator who was available one session per week in the practice to offer support and advice.
- The practice offered annual health checks to patients with a learning disability and support for their carers when necessary.

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. A recall system was in place for injectable medicines and blood tests.
- When a patient did not attend for reviews or medications, their care would be discussed by the nurse and the GP at the practice and further concerns highlighted to the mental health team if necessary.
- 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 practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. Complex and at risk patients were discussed at the clinical team meeting.
- Patients at risk of dementia were identified and offered an assessment using a recognised assessment tool, to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Monitoring care and treatment

The practice had developed a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. We saw that audits were undertaken following significant events and Medicines & Healthcare products Regulatory Agency (MHRA) alerts to ensure that best practice was followed.

Good

Are services effective?

The practice was proactive in their involvement with local and national improvement initiatives. This included participating in the Yorkshire lung screening trial to identify patients at risk of lung cancer, which was noted to be the biggest cancer killer in the area.

- The practice used information about care and treatment to make improvements to the practice and the care offered to patients.

Effective staffing

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

- Staff had appropriate skills, knowledge and training 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 and work with other professionals to enhance care. For example; the practice nurse was liaising with a hospital consultant to improve the identification and screening of chronic obstructive pulmonary disease (COPD). (COPD is the name for a group of lung conditions that cause breathing difficulties.)
- The practice provided staff with ongoing support. This included an induction process, meetings, clinical supervision and support for revalidation. Clinical staff were allocated mentors for ongoing support.
- The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- The practice had introduced documented appraisals for the staff team which were reviewed every four months to ensure ongoing support.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including health visitors, district nurses and social prescribers 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 with, and liaised with, voluntary and community services, social services and carers for housebound patients and with health visitors and community services for children.
- 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.
- We saw evidence that clinicians 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 care of these patients was reviewed every two weeks.

Helping patients to live healthier lives

Staff told us they were committed to 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. There was an identified carers champion at the practice.
- 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 supported local and national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and a campaign to identify the early signs of lung cancer.

Good

Are services effective?

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- National GP patient survey data from July 2017 showed that patients rated clinicians positively. Data showed that 100% of patients said they had confidence and trust in the last nurse they saw or spoke to and 99% of patients said the last nurse they saw or spoke with was good at treating them 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, through interpreters, by using communication aids or accessing easy read materials.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this and supported staff to improve.
- The practice complied with the Data Protection Act 1998. They showed us they were prepared for the new requirements in line with General Data Protection Regulator (GDPR). Patients could download information regarding this change from the practice website.

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 diverse needs and challenges of its population and tailored services in response to those needs.
- Telephone GP consultations, on-line prescription requests and appointment booking; including out of hours appointments were available; which supported patients who were unable to attend the practice during normal working hours. The practice was able to monitor access to appointments during the day and respond appropriately.
- The facilities and premises were accessible and appropriate for the services delivered.
- 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. Patients could be referred to a social prescribing clinic held each week or to the women's counselling team who also held a session at 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:

- The practice held a register of patients who were identified as frail. The patient and their family (where appropriate) would be included in the development of a care plan. Daily telephone triage and same day access to appointments was available for this group of patients.
- 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 maintained close links with a charity for older people which was able to specifically respond to the cultural needs of a large percentage of the elderly practice population.

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. The practice was moving towards the annual review of multiple conditions at one appointment, around the time of the patient's birthday.
- Consultation times were flexible to meet each patient's specific needs and clinicians would often complete opportunistic reviews when patients attended for other issues.
- The practice held regular documented meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice ran a young person's drop in clinic which was supported by staff with skills in sexual health. This was also open to patients not registered with the practice
- 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 were offered a same day appointment when necessary.

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

- Working age people could access a nurse or a HCA for an out of hour's appointment on a Tuesday once per fortnight. GPs appointments were available every week.
- 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. Patients could attend appointments out of hours on a Tuesday evening at the practice and also allocated appointments, Monday to Thursday and on Saturday mornings at neighbouring practices. Telephone appointments were also available.

People whose circumstances make them vulnerable:

- The practice could refer to a women's counselling team which also had the ability to support patients who did not have English as their first language.

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including refugees, homeless people, travellers and those with a learning disability. Patients with a learning disability were offered an annual health check.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

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

- A weekly clinic was held in the practice to support those with mental health issues, this included access to a mental health liaison worker and a pharmacist. When the person had a carer the practice were working to ensure that this person was also identified in the patients record.
- Complex or at risk patients with mental health needs were discussed at the clinical team meeting.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. The practice was a dementia friendly service.

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, this included children, those who were vulnerable and older people
- Patients reported that the appointment system had improved and was easy to use.

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. The practice had a complaint policy in place and a leaflet which detailed how to complain. Patients who made complaints were treated 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?

At the inspection on 23 August 2017 we rated the practice as requires improvement for providing well-led services. A breach of the regulations of the Health and Social Care Act 2008 was found which impacted on the rating in this key question. At this inspection on 29 May 2018, we saw that actions had been taken to resolve those concerns.

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.
- Staff told us that 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. All staff were aware of this and were committed to providing high quality outcomes. The strategy and business plan was formulated annually by the partners of the organisation during an away day. The practice developed its vision, values and strategy to incorporate feedback from patients, staff and external partners.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The partners used intelligence and data to devise key objectives and a yearly plan which reflected initiatives and was in line with health and social priorities across the region.
- The resulting action plan was consistency reviewed through partners meetings, with outcomes and actions noted.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values and supported staff to improve when their performance fell short of expectations.
- 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 at all levels within the organisation and were encouraged to do so. They had confidence that these would be addressed. The practice commissioned an independent report in November 2017 on the services provided. It stated 'staff confirmed that notable improvements had been made in the quality of leadership , communication, resources, procedures and systems which support staff to deliver even higher quality services.'
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year and these were supported by regular reviews and ongoing access to a mentor. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. We saw that when necessary, working times had been adjusted to ensure that staff remained safe at work.
- The practice actively promoted equality and diversity and a policy was in place to support this. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were supportive and positive relationships between staff and teams.

Governance arrangements

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

Good

Are services well-led?

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

Managing risks, issues and performance

There were clear and effective clarity around 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. Where risks were identified we saw that they were responded to. For example, an evacuation sledge was available for staff to assist in the evacuation of less mobile patients in case of fire.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints. These were effectively managed and actions documented.
- The practice had undertaken a number of clinical audits which had a positive impact on the quality of care and outcomes for patients. Where issues were identified we saw that care and treatment was adjusted to reflect best practice. There was clear evidence of action to change practice to improve quality. An ongoing plan for audit and quality improvement activity was in place.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. We saw that meetings, including nurse meetings, were comprehensive and documented. Staff were provided with the information they needed to understand the priorities and performance of the practice.
- The information used to monitor performance and the delivery of quality care was accurate and useful. Plans which were in place to address any identified weaknesses were regularly reviewed.
- The practice used information technology systems to monitor and improve the quality of care. Alerts were placed on patient records to highlight any support required when necessary.
- 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 which ran sessions and engagement events for patients. This was supported by the practice and staff attended regularly.
- Patients were asked for their opinion through a suggestions box and could vote for the staff member who they felt had been their 'Star of the month'.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

Good

Are services well-led?

- There was a focus on continuous learning and improvement. The lead GP was a GP trainer and had recently begun to offer training opportunities to student GPs.
- The practice continued to work with other practices in the local area and were proactively looking for opportunities to improve patient care.
- The practice made use of internal and external reviews of incidents and complaints. The practice had significantly improved how learning was shared and this information was 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.