Montague Medical Practice

Inspection report

Montague Medical Centre
Fifth Avenue
Goole
Humberside
DN14 6JD
Tel: 08444772596
https://www.montaguemedicalpractice.co.uk/

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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 November 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 Montague Medical Practice on 13 June 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Take action to complete infection control audits at recommended intervals.
- Develop a protocol for inhaler use in spirometry clinics.
- Improve the process for receiving and assessing new clinical guidance.
- Take action to promote Patient Participation Group information in the waiting area and on the practice website.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

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

Population group ratings

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

Our inspection team

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

Background to Montague Medical Practice

Montague Medical Practice, Fifth Avenue, Goole, DN14 6JD is in a purpose-built property in the town of Goole, East Yorkshire. Parking is available at the practice. Consulting and treatment rooms are all on the ground floor.

The practice provides services under a General Medical Services (GMS) contract with the NHS North Yorkshire and Humber Area Team to the practice population of 9232, covering patients of all ages.

The provider is registered with the Care Quality Commission to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The proportion of the practice population in the 65 and over age groups is lower than the local CCG average and similar to the England average. The proportion of the practice population in the under 18 years age group is similar to the local CCG and England average. The practice scored five on the deprivation measurement scale, the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have greater need for health services.

The practice has three GP Partners, one male and two females, two work full-time and one part-time. There are three advanced nurse practitioners, three practice nurses and one health care assistants, all work part-time and all are female. There is a practice manager, assistant practice manager and a team of administration, reception and secretarial staff.

The surgery is open between 8am to 6pm Monday to Friday. The practice has an 'on the day' appointment system. Patients contact the surgery between 8am and 11am on the day they wish to be seen. The receptionist asks patients to provide a brief indication of why they were calling and then tells the patient that one of the clinicians will ring them back to discuss their needs and arrange whatever care is necessary. Pre-bookable appointments are available on Monday mornings. The practice is also open on Saturday mornings for pre-bookable appointments.

The practice, along with all other practices in the East Riding of Yorkshire CCG area have a contractual agreement for the Out of Hours provider to provide OOHs services from 6.00pm on weeknights. This has been agreed with the NHS England area team.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. One of the ANPs told us they were trained to level three in safeguarding children however, the practice was unable to provide evidence that the three advanced nurse practitioners had attended safeguarding level three training. They knew how to identify and report concerns. Learning from safeguarding incidents were 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.)
- 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. We checked three staff files and found that one had only one reference and another only one piece of photographic ID, both should have had two of each.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- 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.

Good

Are services safe?

- 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. The percentage of antibiotic items prescribed by the practice that were Co-Amoxiclav, Cephalosporins or Quinolones between July 2016 to June 2017 was positive. Practice rates were 3% below the local CCG average and 5% below the England average.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- 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 the population groups as good for providing effective services .

Effective needs assessment, care and treatment

Clinicians 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.

- Staff accessed clinical guidelines from various sources including CCG updates, NICE website updates and Public Health England. We saw examples of when they had reviewed and acted on it. However, there was no formal process in place for receiving and assessing new guidance.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice wrote to patients when they were 75 years old to inform them of their named GP and included in the letter an invitation to make an appointment for a health check at the surgery.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice took part in the routine and catch up shingles vaccination programme and the influenza vaccination programme.
- There was a named GP for each of the care homes where the practice's patients lived.

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. Patients had a review of their medication by a pharmacist to identify any medicine usage issues prior to their appointment. All patients were offered a personalised care plan.
- Where necessary, patients were referred to educational services such as Living with Diabetes and all diabetic patients were referred for retinal screening.
- There was a robust call and recall procedure, sending three invitations as a minimum for patients who do not attend for their reviews.
- Staff who were responsible for reviews of patients with long term conditions had received specific training, for example, diabetes, asthma and respiratory disease.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered 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's performance on quality indicators for long term conditions was in line with local CCG and England averages.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% for the four indicators and was above 95% for three of the four indicators.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice linked with the midwifery teams at the local hospital and shared the care of expectant mothers. Postnatal mother and baby checks were carried out and practice staff worked closely with the Health Visiting team.

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

- The practice's uptake for cervical screening was 70%, which was below the 80% coverage target for the national screening programme. The practice was aware of this and raised awareness of cervical screening in the waiting area and on the practice website. Appointments were available at different times throughout the week and female sample-takers were available. Women

received a written invitation, and three written reminders were sent if they did not attend. The practice nurse also phoned some women to encourage them to attend. If women did not attend this was flagged on their record so that the screening test could be discussed opportunistically. The practice nurse was planning to do an awareness exercise in the practice during the cervical screening awareness week in June 2019.

- The practice's uptake for breast and bowel cancer screening was similar to the national average. Information was displayed in the waiting room on breast and bowel cancer 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 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice offered family planning and contraceptive services, including the fitting of coils, and long acting contraceptives. The practice had recently introduced using a contraceptive which provided an alternative option to patients to self-inject rather than having to attend the surgery. Twenty-three patients were now using the self-injection contraceptive.
- The practice proactively contacted patients who were aged 45 or over to offer them an appointment for a blood pressure check, 300 patients had been offered a check since January 2018.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients with Learning Disabilities (LD) were offered an annual review, including a review of their medication. Appointments were offered to suit the individual and often their carer to encourage attendance. Some staff had attended training for the LD reviews.
- 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.
- 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 practices performance on quality indicators for mental health was in line with the local CCG and England averages.

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.

- The practice exception rates for some indicators were above the local CCG or national average. (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.) The practice had engaged an external company in January 2018 who had worked with practice staff to look at the reasons for this. For example, two practice nurses that did asthma and respiratory disease (COPD) reviews had left and one of the GPs had been doing them. Therefore, the practice had implemented stricter criteria for patients who did not attend appointments. They were sent three letters inviting them for review and if they did not attend they were exception reported resulting in a higher percentage. Also, some training needs had been identified for staff to ensure that details about the patients' condition were coded correctly in clinical records.

Good

Are services effective?

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- 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 discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- 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 practices national GP patient survey results were in line with local CCG and England averages for questions relating to involvement in decisions about care and treatment and explaining treatment and test results for the GPs. For nurses the results were above the local CCG and England averages.

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 the population groups, as good for providing responsive services .

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours. Patients could also submit queries and requests on line via the practice website and would receive a response by the end of the next working day.
- The facilities and premises were 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 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 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 communicated regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Saturday morning appointments were available for working patients and children who could not attend the surgery during school time.

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. For example, extended opening hours with Saturday appointments.
- The practice used the Electronic Prescribing System which allowed patients who work to collect prescriptions from a pharmacy of their choice which may be closer to where they work.
- Online access to book appointments and order prescriptions was available enabling patients to do this at their convenience and not to have to find time to do this during their working day. This service had been suspended when the new appointment system was introduced. However, it had been re-introduced and there was a display in the waiting area informing patients they could use the online system, how to access it and encouraging patients to use it.
- Telephone consultations were available for patients that might not be able to access the surgery during normal hours.

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.
- The practice had a high proportion of the migrant population registered as patients and worked closely with the Migrant Support Service. They offered

Good

Are services responsive to people's needs?

telephone and written translation services to patients whose first language was not English. Representatives from the Migrant Support Service also attend the practice Patient Participation Group meetings.
- A 'Community Link' worker (Social prescribing) worked in the practice one day per week. GPs and nurses who saw patients and identified an unmet social need were able to refer patients to this service. They would make contact with the patient and invite them in for an assessment and offer the support and help they need. The community link worker could signpost patients to a variety of services including the Health Trainers, East Riding leisure services and other voluntary/third sector support groups.

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 was proactive in diagnosing patients with dementia and offered full support to patients, their families and carers. They had meetings with the local Dementia lead to discuss improvements to the service they offered and had been involved in the local Goole Dementia Project. This involved Dementia Nurses visiting care homes to assess patients and provide training and awareness to the care home staff and the patients' families.
- Patients were referred or signposted to the IAPT (improving access to psychological therapies) service.
- There was an in-house counsellor who the practice could refer directly to for patients who required support with drugs and/or alcohol problems.
- Patients who may be suffering with anxiety/low level mental health issues were referred to the in-house Community Link worker.

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.
- The practices GP patient survey results published in July 2017 were below local CCG and England averages for questions relating to access to care and treatment. The practice had reviewed and changed its appointment system since the results were published. The practice was planning to undertake a patient survey to gather views on the new system. Also, a new telephone system was going to be installed as part of the refurbishment project that was commencing in November 2018. This would provide more lines into the practice and a choice of services in the practice to choose the one they wanted to access. A 'queuing' system to tell patients how many people were in front of them would also be available.

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 plan 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 behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received an annual appraisal 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. Some staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted 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 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.
- 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.

Good

Are services well-led?

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

The practice strived to involve 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. For example, following feedback from patients the online appointment system had been re-instated. However feedback from the PPG said they were not always informed of changes in the practice before they happened.
- There was an active patient participation group (PPG). The group was scheduled to meet quarterly however recently meetings had not taken every six months. Information on the PPG was available on the practice website which encouraged new members, however there was no information in the waiting area about the PPG. Minutes of meetings were not available on the website and the most recent annual report available was for 2014/2015.
- The service was transparent, collaborative and open with stakeholders about performance.
- One of the GPs was an affiliated member of the Local Medical Committee.
- The practice had recently taken part in a care home workshop organised by the CCG locality team.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- 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.