

Topsham Surgery

Inspection report

Holman Way

Topsham

Exeter

Devon

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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 July 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 Topsham Surgery on 24 July 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 practice worked closely with a local charity and one of the practice GPs chaired the local Estuary League of Friends which offered befriending and support for patients without family or friends and helped them access benefits and arrange social or personal care.
- The practice provided care plans and annual reviews to patients at a local drug and alcohol dependency unit which housed approximately 35 patients.
- The practice participated in the clinical commissioning group Referrals Enhanced Service. This was a service which provided reasons for referrals, examined any outliers and offered specialist support as a result. For example, a musculoskeletal (MSK) specialist had visited the practice to give a presentation to GPs following high numbers of referrals to a MSK specialist.

We saw two areas of outstanding practice:

- There was supported housing for survivors of domestic abuse and a home for patients with long term mental illness within the practice area. The nurse manager provided in-house training for staff at these homes, as well as providing appropriate vaccinations and regular health checks.
- The practice provided a weekly surgery at the West of England School for the blind and partially sighted. This provided a high level of care and treatment for around 40 children and young adults with complex special needs and complex prescribing.

Professor Steve Field CBE FRCP FFPH FRCGP Chief Inspector of General Practice

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

Population group ratings

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

Our inspection team

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

Background to Topsham Surgery

This report relates to the regulatory activities being carried out at Topsham Surgery which is situated in the coastal town of Topsham. Topsham Surgery is comprised of two sites; the main site is at Holman Way, Topsham EX3 0EN and the branch surgery is located at Glasshouse Lane, Countess Wear, Exeter EX2 7BT. We visited both these sites during our inspection. The practice has a website which is located at www.topshamsurgery.gpsurgery.net.

The deprivation decile rating for this area is nine (with one being the most deprived and 10 being the least deprived). The practice provides a primary medical service to approximately 10,750 patients of a diverse age group. The 2011 census data showed that majority of the local population identified themselves as being White British.

There is a team of eight GP partners, four female and four male; the partners are supported by one salaried GP and two GP registrars. The whole time equivalent of GPs is approximately five. The GP team were supported by a practice manager, an office manager, an information technology manager, an administration manager, four practice nurses, three health care assistants and additional administration staff.

Patients using the practice also have access to health visitors, counsellors, carer support workers, district nurses, midwives and other health care professionals who visited the practice on a regular basis.

The Topsham location is open from 8.30am to 6pm Monday to Friday. The Glasshouse location is open 8.30am to 5.30pm. Appointments are offered between those times. Extended hours are offered at Topsham from 6.30pm until 7.45pm Monday to Thursday and two Saturday mornings a month from 9.30am until 1pm. Outside of these times, including from 8am to 8.30am and 6 to 6:30pm, patients are directed to contact the out of hour's service and the NHS 111 number. This is in line with local contract arrangements.

The practice offers a range of appointment types including face to face same day appointments, telephone consultations and advance appointments (six weeks in advance) as well as online services such as repeat prescriptions.

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. 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.
- 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.
- 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.
- There were effective protocols for verifying the identity of patients during remote or online consultations.
- 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.

Are services safe?

- 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.

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall except vulnerable people, which we rated as outstanding.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had completed a trial of e-consult whereby patients can ask their GP clinical questions by e-mail. The results of this trial were being reviewed at the time of our inspection.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- GP partners maintained personal lists of patients in the interest of good care and continuity for patients. Many elderly patients have had the same GP for over twenty years. Patients' GPs conducted regular medication reviews and provided long term condition management.
- The practice encouraged repeat dispensing of regular medication and liaised closely with community pharmacists to identify patients who would benefit from blister pack dispensing to improve compliance where

complicated medicines are used. The practice had piloted the employment of an in-house pharmacist to carry out medication reviews and advise clinicians on best practice.

- The practice worked with the local hospital trust to identify high risk patients using a frailty index and these patients were closely monitored and managed. The practice used the acute community team via the single point of access system to provide timely support for patients in crisis with the aim that unnecessary hospital admissions would be prevented.
- The practice was mindful of the social isolation experienced by many elderly patients and with the help of the local Estuary League of Friends the practice referred these patients to the Wellbeing Exeter social prescribing project. This helped patients to access social and emotional support.

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 example, the practice provided a specialist diabetic clinic once a quarter for approximately 12 patients (a total of 48 patients a year). This provided a review of their treatment and updated it where appropriate in line with the latest guidance.
- 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.
- 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 was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice maintained up to date registers and recall systems for the management of patients with long-term conditions and had achieved maximal Quality Outcome Framework (QOF) scores each year. The practice had a

Are services effective?

well organised system for arranging regular blood test monitoring where needed for safe prescribing and had in-house specialist nurse clinics for asthma, diabetes and other conditions. The practice offered a virtual diabetes clinic run with the help of a local specialist diabetes centre. We saw evidence of positive feedback from other health professionals about the practice.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above. In three of the four indicators the practice achieved over 95%. The practice achieved 100% vaccination rate of children aged two who had received immunisation for measles, mumps and rubella.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice provided all new parents with a welcome pack when their baby was born explaining how they could register their infant and what services the practice offered to them. New parents were invited for postnatal examinations and an eight-week child health screening carried out by one of the GPs.
- Immunisation appointments were sent out and nurses provided patient education and immunisations. The practice reached a very high level of immunisation according to statistics received.
- The GP safeguarding lead attended the Exeter wide GP Group and shared good practice with the other practices. The practice contributed to child in need multidisciplinary meetings with reports and met local health visitors quarterly to exchange information.
- The practice provided same day appointments for unwell children at both practices.

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

- The practice's uptake for breast and bowel cancer screening was comparable with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

- The practice provided out of hours cytology clinics four times a month to support working patients who were unable to attend during office hours. Each of these four clinics provided eight appointments (32 a month in total) and were always full. This had enabled the practice to achieve a cervical screening uptake rate of 76% which was higher than the Clinical Commissioning Group average of 75% and the current national average achievement of 72%. The practice continued to work towards achieving the national target of 80%.

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.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice provided care plans and annual reviews to patients at a local drug and alcohol dependency unit which housed approximately 35 patients.
- The practice referred patients in need to the local Estuary League of Friends who offered befriending and support for patients without family or friends and helped them access benefits and arranged social or personal care.
- There was supported housing for survivors of domestic abuse and a home for patients with long term mental illness in the practice area. The nurse manager provided in-house training for this home's staff which enabled them to give vaccines and provide regular health checks.
- The practice operated a GPs personal patient list system for patients whose circumstances made them vulnerable which provided continuity of care and consistency in prescribing and management.
- The practice provided a weekly surgery at the West of England School for the blind and partially sighted. This provided a high level of care and treatment for around 40 children and young adults with complex special needs and complex prescribing.

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

Are services effective?

- 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 practice offered annual health checks to patients with a learning disability.
- The practice had achieved accreditation to become a dementia friendly practice and all staff had received appropriate training in this field.

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 used information about care and treatment to make improvements. For example, the introduction of care plans and annual reviews to patients at a local drug and alcohol dependency unit which housed approximately 35 patients. The practice had acted upon the findings of continuous improvement audits to operate a GP's personal patient list system for patients whose circumstances made them vulnerable which provided continuity of care and consistency in prescribing and management.

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.

Are services effective?

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients on end of life care, 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.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.
- The practice provided a weekly surgery at the West of England School for the blind and partially sighted. This provided a high level of care and treatment for around 40 children and young adults with complex special needs and complex prescribing.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- The practice was in the process of reviewing its military veterans' policy on the Armed Forces Covenant 2014. The requirements of this legislation included the identification of military veterans to enable priority access to secondary care for those patients with medical conditions arising from their service to their country.

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 consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

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. 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.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.

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.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

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.

Are services responsive to people's needs?

- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.

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.

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.

- The practice had completed the productive general practice programme (PGPP) recommended by NHS England. The PGPP which provided a framework to assist staff in examining existing systems and processes with a view to continuous improvement and workflow optimisation. Staff ideas which had been implemented included a new recall system. A traffic light system was set up which prioritised patients according to clinical need including any chronic conditions. The new system signposted patients to the most relevant support service, whether that was a GP, nurse, health care assistant, pharmacist, or other health professional.
- 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 which were included in the staff handbook. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Future challenges which the practice had planned for included an extension of their branch location for additional clinical rooms and the re-housing of the community nursing team in order to retain them on site at the practice.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice had experienced GP partner changes in the last three years. The practice strategy had succession planning in place for this and two GP registrars trained at the practice were becoming or had become GP partners.

- 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 received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

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.

Are services well-led?

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the practice had created a social media group to keep staff and patients informed about changes to the practice and potential risk to safety during the adverse weather conditions experienced in February and March 2018.
- 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.

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 arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.