Oulton 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. (A previous inspection undertaken on 7 October 2014 had rated the practice as Good overall.)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Oulton Medical Practice on 15 May 2018, as part of our inspection programme.

At this inspection we found:

- The practice had clear governance policies and protocols, which were accessible to all staff. There were clear systems in place 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.
- Patient care and treatment was delivered in line with up to date best practice guidance. There was evidence of quality improvement within the practice. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- There were a range of clinical staff to support delivery of care to their patient population, for example a named advanced nurse practitioner for older people and a GP lead for frailty.
- The practice offered patients a range of access to appointments, such as telephone consultations and extended hours. Patients also had access to Saturday morning appointments with a range of clinicians, such as GP, advanced nurse practitioner and physiotherapist.
- Uptake rates for cancer screening programmes were higher than local and national averages.
- There was a good use of skill mix and the practice were engaged with innovative schemes to support quality patient care and service delivery.
- Patients in the main were positive about the service, care and treatment they received at the practice.
- There was evidence of a cohesive team with a strong focus on continuous learning and improvement at all levels of the organisation.

We saw an area of outstanding practice:

- There was a good use of skill mix and a comprehensive, co-ordinated approach to support care and treatment provided to those patients who were elderly, frail or had mental health needs.

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

Population group ratings

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

Our inspection team

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

Background to Oulton Medical Centre

Oulton Medical Practice is the provider of the practice which has two locations: Oulton Medical Centre, Quarry Hill, Oulton, Leeds LS26 8SZ and Marsh Street Surgery, 25a March Street, Rothwell, Leeds LS26 0AG. These are both based within the South East area of Leeds. As part of the inspection we visited both locations.

The premises at Oulton Medical Practice and Marsh Street Surgery are owned by the GP partners.

The provider is contracted to provide Personal Medical Services to a registered population of approximately 13,774 patients. There are some variables to the practice patient profile compared to national figures. For example, the percentage of patients whose working status is classed as being unemployed is 2% (5% nationally) and the percentage of patients who have a long-standing health condition is 37% (54% nationally).

The ethnicity of the practice patient population is approximately 97% white British with the remaining 3% from mixed ethnic groups. The National General Practice Profile shows the level of deprivation within the practice demographics being rated as seven. (This is based on a scale of one to ten, with one representing the highest level of deprivation and ten the lowest.)

The provider is registered with Care Quality Commission to provide the following regulated activities: diagnostic and screening procedures; treatment of disease, disorder or injury; maternity and midwifery services; family planning and surgical procedures.

The practice clinical team is made up of eight GP partners (six female, two male), two advanced nurse practitioners, three practice nurses, four healthcare assistants and a clinical pharmacist. Staff rotate across all the sites. The administration team consist of a practice manager, an assistant practice manager and a large team of reception and administrative staff.

Opening times for Oulton Medical Centre are 8am to 6pm Monday to Friday. Extended hours are Mondays 6pm to 8pm and Fridays 7am to 8am.

Opening times for Marsh Street Surgery are 8am to 6pm Monday to Friday. Extended hours are from 7am to 8am on Tuesdays.

At both locations urgent appointments are available and routine appointments are pre-bookable up to four weeks in advance. Patients can also make appointments via the practice's online portal on their website. When the practice is closed out-of-hours serviced are provided by Local Care Direct, which can be accessed by calling the NHS 111 service.

The practice worked collaboratively with two other local practices to provide acute appointments on Saturdays. Appointments for patients were available with a range of multidisciplinary staff, which included GPs, nurses, a healthcare assistant, phlebotomist and physiotherapist.

The practice is a training practice and accommodates GP Registrars and medical students. GP Registrars are fully qualified doctors who are completing their specialist training to become a GP.

We saw that the ratings from the previous inspection were displayed both in the practice and on the website at www.oultonmedicalcentre.co.uk

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. They knew how to identify and report concerns. Staff gave us several examples where they had addressed some safeguarding concerns.
- All staff who acted in the capacity of a chaperone had been trained and 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 worked with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. There were up to date audits and evidence of completed actions for both of the practice locations.
- The practice had arrangements to ensure that facilities and equipment were safe, regularly maintained and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were 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. These included planning for holidays, sickness, busy periods and epidemics. This planning avoided the need for regular locum use.
- 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. We were given an example where a GP had identified sepsis in a patient and had arranged for urgent hospital admission.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- There was a system in place to manage patient safety alerts. These were cascaded to staff, discussed in clinical meetings and actioned as appropriate. We saw the practice had taken action in response to a recent (April 2018) Medicines and Healthcare products Regulatory Agency (MHRA) drug safety alert, regarding the regulatory measures of the prescribing sodium valproate in women or girls of child bearing age.

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 clear approach to managing test results. The patient service team leader undertook monthly random checks to ensure letters were summarised and coded in patients' records correctly.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Regular multidisciplinary meetings were held with other community staff, such as the district nurse, palliative care team and health visitors. Patients' records were updated with relevant information arising from those meetings.
- 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.
- Medicines were prescribed, administered or supplied to patients in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial management in line with local and national guidance.

Good

Are services safe?

- Patients were reviewed and their health monitored in relation to the use of medicines and followed up on appropriately.
- Those patients who were prescribed high risk medicines received regular reviews in line with national guidance.

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 activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for reporting and recording any areas of concern. Staff understood their duty to report incidents and near misses and were encouraged and supported to do so.
- There were 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 Table for further information.

Good

Are services effective?

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

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice.

- Patients' needs, along with their mental and physical wellbeing, were assessed by clinicians. Care and treatment were delivered in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- Clinical templates were used, where appropriate, to support decision making and ensure best practice guidance was followed.
- Clinical staff were aware of social prescribing and signposted patients to other avenues of support as appropriate.
- Patients were advised where to seek further help and support should their condition deteriorate.
- There was no evidence of discrimination when clinicians made care and treatment decisions.

Older people:

- An appropriate tool was used to identify patients aged 65 years and over who were living with moderate or severe frailty. Those identified as being frail received a holistic review of their care and treatment needs.
- The practice followed up on older patients who were discharged from hospital. They ensured that patients' care plans and prescriptions were updated to reflect any extra or changed needs.
- There was a nominated advanced nurse practitioner (ANP) for older people, who also liaised with the local care homes where the practice had registered patients. The ANP discussed end of life care planning with those patients and their families as appropriate, to ensure patients' wishes were identified.
- One of the GPs was the frailty lead for the CCG and staff had appropriate knowledge of treating older people, including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice provided care and treatment for adult patients who were newly diagnosed with cardiovascular disease, which included the offer of high-intensity statins for secondary prevention. Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate. Any patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- QOF outcomes for 2016/17 showed the practice were above average for achievements in long-term conditions indicators, which included the ongoing management of patients with those conditions.

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 higher than the national target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Clinicians liaised regularly with the health visiting team, to support appropriate care was available for children and families.
- All new patients aged 16 years and under were offered a health check.
- A drop-in sexual health clinic was held each week. Patients could also access sexual health advice through regular appointments.

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

- At 80%, the practice's uptake for cervical screening in 2016/17 was higher than the national coverage target of 72%.

Good

Are services effective?

- At 84% and 68% respectively, the practices' uptake for breast and bowel cancer screening was also higher than the national average (70% and 55%).
- The practice offered catch-up vaccinations for measles, mumps and rubella (MMR) and meningitis for patients, such as students before they were attending university or college.
- 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 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 had a learning disability.
- Annual health checks were offered to patients who had a learning disability. These patients were also signposted to other appropriate services for additional support.
- 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):

- Patients who had complex mental health needs or dementia had their care reviewed in a face to face consultation with a clinician. The percentage of those patients who had received a review was slightly higher than national averages.
- 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.
- Those patients who were on long-term or high-risk medication were reviewed in line with guidance.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. In those instances where dementia was suspected there was an appropriate referral for diagnosis.
- There was an ANP lead for learning disabilities. They supported patients to received regular reviews of their care and treatment and liaised with the CCG learning disabilities lead nurse as appropriate.

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.

- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives, such as QOF and the primary mental health service collaboration with local practices.
- The QOF results for 2016/17 showed the practice was performing higher than CCG and national averages in some areas.
- A programme of audit was used to drive quality improvements in clinical care and service delivery. We reviewed several audits, which included full cycle audits on gestational diabetes and minor surgery. These all showed quality improvement.
- The practice participated in local quality incentive schemes, such as medicines optimisation. They also used information provided by the CCG to identify and address any areas for improvement.

Effective staffing

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

- The practice had reviewed the skills needed to provide the care and service delivery for patients. Consequently, there was a range of roles which included advanced nurse practitioner and a clinical pharmacist.
- We saw evidence that staff were up to date with mandatory training, such as fire safety, safeguarding and infection prevention and control.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice provided staff with ongoing support, through an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.

Coordinating care and treatment

Practice staff worked together, and with other health and social care professionals, to deliver effective care and treatment.

Good

Are services effective?

- We saw records which showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- Care was coordinated between services and those patients who received 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 held bi-monthly multidisciplinary meetings to support management of patients who were identified as being at high risk of having an unplanned hospital admission.
- The advanced nurse practitioner (ANP) regularly visited a large local care home, to ensure coordinated care was delivered between the practice and the nursing home staff. The ANP also worked closely with the Consultant Community Geriatrician and relevant neighbourhood teams to provide a patient focused service.
- 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.
- Discussion of safeguarding and vulnerable patients was a standing agenda item at the weekly clinical meetings.

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, the frailty and falls prevention scheme.
- Healthy lifestyle information and interventions, such as smoking cessation, alcohol misuse and social prescribing, were available for patients. In addition, patients had access on a weekly basis to a 'healthy lifestyle service' facilitated by an appropriately qualified personal trainer who specialised in GP exercise referrals.
- The practice participated in the collaborative Primary Care Mental Health pilot project. A mental health worker was based in the practice and provided a structured discharge from secondary care. This was for patients who had been stable for long periods and were complaint with their medication. Patients could be seen at the practice, rather than secondary care services, to provide support and avoid them relapsing.

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 Table 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.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The NHS Friends and Family Test is a survey which asks patients if they would recommend the practice to their friends and family, based on the quality of care they have received. The results in the preceding quarter showed that out of 73 responses, 90% of patients would recommend the practice, 5% would not and 5% did not know. The results were reviewed on a monthly basis and any comments responded to.
- The practice undertook their own patient satisfaction survey on an annual basis. We saw evidence where actions had been taken to address any negative areas. For example, acknowledging patients' comments about feeling listened to.
- Feedback from patients we received via CQC comment cards was positive about the way staff treat people.

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 and had access to communication aids such as a hearing loop and translation services.
- The practice identified patients who were a carer for another person and support was provided at an individual level.
- Patients and carers were signposted to advocacy services that could support them in making decisions about their care and treatment if needed.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Patients' comments we received on the day of inspection supported this.
- 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.

Please refer to the Evidence Table 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 understood the needs of its population and tailored services in response to those needs.

- Care and treatment for patients approaching the end of life was coordinated with other services.
- Patients were supported to access additional avenues of support, such as community services and voluntary organisations.
- The practice worked collaboratively with two other local practices to provide acute appointments on Saturdays. Appointments for patients were available with a range of multidisciplinary staff, which included GPs, nurses, a healthcare assistant, phlebotomist and physiotherapist.
- The facilities and premises were appropriate for the services delivered. The practice made reasonable adjustments when patients found it hard to access services.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice made use of a frailty register which enabled them to identify those patients who were at a higher risk of illness or injury and supported them to respond quickly to areas of concern.
- The practice participated in a local community care beds service pilot. The aim of the pilot was, where appropriate, to enable effective early discharge from hospital or prevent an unnecessary hospital admission.
- Registered patients who were resident in care homes were visited on a minimum weekly basis with additional visits as needed.
- The ANP liaised regularly with the local neighbourhood team to discuss and manage those patients with complex 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.
- Care was co-ordinated with other health care professionals, such as district nurses, to support patients who were housebound.
- Patients who had complex needs due to their long-term condition were supported by a range of clinical staff, which included independent nurse prescribers. This prevented the need for unnecessary admissions to secondary care.

Families, children and young people:

- 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.
- There was access to emergency appointments or telephone consultations for those parents who had concerns regarding their child's health.
- Weekly ante-natal clinics were held by a midwife and supported by the GPs. Post-natal checks were undertaken by the GPs.
- There was a weekly drop-in family planning clinic, where patients also had access to coil or contraceptive implants.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered telephone consultations, extended hours appointments and urgent assessment clinics at both practice locations. Appointments with a range of clinical staff were also available on Saturdays.
- Patients were encouraged and supported to access online services, such as booking appointments and ordering prescriptions.

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.
- Longer appointments were available for those patients who had complex needs.
- The practice held a register of carers and supported them as needed.

Good

Are services responsive to people's needs?

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 a register of patients who lived with dementia and utilised appropriate tools to identify early signs of dementia.
- The practice participated in the Primary Care Mental Health pilot and patients had access to a mental health worker. Patients who had been stable for a period of time could be seen at the practice for support, without the need to attend a secondary care 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.

- There was access to a variety of appointments, extended hours, telephone consultations and weekend appointments at the local GP 'hub'.
- The practice operated an urgent assessment clinic from one of the two locations each weekday. Patients with the most urgent needs had their care and treatment prioritised.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- On the day of inspection there were mixed comments from patients regarding access to regular appointments. However, all said that they were able to get an urgent appointment when needed.

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. For example, a patient had written to the practice to complain about having difficulty in booking an appointment in advance. As a result of this complaint and other concerns, the practice had revised their advance booking time from two to four weeks.

Please refer to the Evidence Table 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, challenges and priorities relating to the quality and future of services.
- 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 support leadership skills within their workforce. One of the ANPs had won the 2017 General Practice Nursing (GPN) award for "being a credible and visible nurse leader" and a practice nurse had won the award for "nurse mentor".

Vision and strategy

The practice had a clear vision, a realistic strategy and supporting business plans to deliver high quality, sustainable care.

- All staff were aware of and understood the practice vision and values and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.
- The practice engaged the support of their patient participation group (PPG) in delivering their vision and strategy.

Culture

The practice had a culture of being open and delivering high-quality sustainable care.

- 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 annual appraisals and role development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Any behaviour and performance inconsistent with the vision and values of the practice was acted upon.
- There was a strong emphasis on the safety and well-being of all staff. The practice actively promoted equality and diversity.
- There was evidence of a cohesive team and positive working relationships between all staff. Staff told us they felt respected, supported and valued.

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.
- Staff were clear on their roles and accountabilities, including those in respect of safeguarding and infection prevention and control
- Practice leaders had established comprehensive policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There were a range of meetings where good governance was on the agenda and staff were kept informed.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks, including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. There was a practice oversight of national and local safety alerts, incidents, and complaints.
- There was a programme of clinical audit and quality improvement activity which could evidence positive impacts on the quality of care and outcomes for patients.

Good

Are services well-led?

- 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 staff 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.
- The practice used information technology systems to monitor and improve the quality of care.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- 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, staff and external partners to support high-quality sustainable services.

- The service was transparent, collaborative and open with stakeholders about performance.
- 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.
- The practice engaged with the PPG to discuss priorities of improvement for the practice.
- The PPG were involved in the development of the annual practice patient survey and in reviewing the results.
- Members of staff worked with the local federation of GP practices to support learning and development.

Continuous improvement and innovation

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

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- There was a focus on continuous learning and improvement.
- One of the GPs was the frailty lead within the CCG and had supported early adoption of the frailty scheme within the practice.
- The practice worked collaboratively with other local practices to improve the quality of and access to patient care.

Please refer to the Evidence Table for further information.