

# Clifton Hampden Surgery

## Inspection report

The Surgery, Watery Lane  
Clifton Hampden  
Abingdon  
Oxfordshire  
OX14 3EJ  
Tel: 01865407888  
[www.cliftonhampdensurgery.co.uk](http://www.cliftonhampdensurgery.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.** This was the first inspection of Clifton Hampden Surgery since it was registered with the Care Quality Commission (CQC) as a GP partnership. (Previously the practice was registered to an individual GP and the inspections carried out in December 2016 and July 2017 resulted in a rating of Good).

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 Clifton Hampden Surgery on 22 May 2018. This inspection was carried out because the practice registered as a partnership in September 2017 and all newly registered providers receive an inspection 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.

- 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 focus on continuous learning and improvement at all levels of the organisation.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice regularly reviewed the safety of the premises to deliver health care.
- Patients taking repeat medicines received regular review of their prescriptions.

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

- Review the consistency of recording acknowledgement of complaints.
- Review and update the guidance for reception staff to identify potential serious symptoms patients report when seeking an appointment including sepsis.

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

## Population group ratings

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

## Our inspection team

Our inspection team comprised a CQC lead inspector and a GP specialist adviser.

## Background to Clifton Hampden Surgery

Clifton Hampden Surgery is located in the village of Clifton Hampden and provides services to a predominantly rural population of approximately 3,290 patients. Clifton Hampden Surgery is within two converted semi-detached cottages which were first occupied for the provision of healthcare in 1985.

The practice is situated in an area where there are no nearby pharmacies. It therefore offers a dispensing service to approximately 2,500 of the patients who are registered (These patients live more than one mile (1.6km) from their nearest pharmacy). Nationally reported data shows the practice has a higher than average number of registered patients between 45 and 74 years of age. There are lower than average numbers of patients aged under 45 years of age. There is a similar number of patients aged over 75 compared to the national and local averages. Statistics show the registered population does not suffer from high levels of income deprivation. Where this exists the practice is aware of the patients and their locations. Data also identifies 3.1% of the registered patients are from Asia and non-white ethnic groups.

The GP team comprises three GP partners and a long term locum GP. There are two male and two female GPs that make up two whole time GPs. There are three practice nurses (all female) who all work part time. They are equivalent to one whole time practice nurse. The

practice manager, who is also the dispensary manager, has a team of six administration and dispensing staff working with them to undertake the management and administration support tasks required at the practice.

The practice is open from 8am to 6.30pm every weekday. Extended hours clinics are available from a local GP alliance every evening until 8pm and on Saturday and Sunday mornings.

Face to face appointments are offered between 9am and 12.30pm every weekday morning. On Monday and Thursday afternoons appointments are offered between 4pm and 6pm. On the remaining three weekdays there are two GPs on duty who offer telephone appointments and triage, urgent appointments at the practice and home visits.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by Oxford Health NHS Foundation Trust. The out of hours service is accessed by calling NHS 111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice and in the practice information leaflet.

Services are provided via a General Medical Services (GMS) contract. (A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. All services are provided at:

Clifton Hampden Surgery

Watery Lane

Clifton Hampden

Abingdon

Oxfordshire

OX14 3EJ

The practice is registered with CQC to provide:

- Treatment of disease disorder and injury
- Diagnostic and screening procedures
- Maternity and midwifery
- Family planning and
- Surgical procedures

Further information about the practice can be found on their website at:

[www.cliftonhampdensurgery.co.uk](http://www.cliftonhampdensurgery.co.uk)

# Are services safe?

**We rated the practice as good for providing safe services.**

## Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment 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 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. However, guidance for reception staff to be alert to sepsis symptoms was not included in appointment booking protocols.

- When there were changes to services or staff the practice assessed and monitored the impact on safety.

## Information to deliver safe care and treatment

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

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

## Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- 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.
- Arrangements for dispensing medicines at the practice kept patients safe.

## 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.

# Are services safe?

## 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. For example,

the practice had a written action plan to address dispensing errors. Leaders had identified that whilst the volume of dispensing errors was below national average that improvement in dispensing systems could further reduce errors.

- 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.

Please note: Any Quality Outcomes (QOF) data relates to 2016/17 when all three of the current partners were working at the practice but the registration was held by one GP. (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 have 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 provided patients with blood pressure monitors to use at home to take their blood pressure readings when this was appropriate. There was also a 24 hour ECG monitor which patients could be provided with to monitor their heart rate at home.
- Clinical staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

#### Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental, social and communication needs.

#### 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.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- 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)
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#### 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 above the target percentage of 90%. The practice achieved over 95% take up of immunisations for four immunisations given to children aged two.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 88%, which was above the 80% coverage target for the national screening programme.

## Are services effective?

- The practices' uptake for breast and bowel cancer screening was better than the local and 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.

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.
- Health checks and flu immunisations were offered to patients with a caring responsibility.

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 high risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 91% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those

living with dementia. For example 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is above the national average.

- 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.

### Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there was a clinical audit programme in place. This included an audit of patients usage of their medicines which ensured over 90% of patients taking repeat medicines received a six monthly review of their prescriptions and were given advice on any side effects or support to take their medicines appropriately. Where appropriate, clinicians took part in local and national improvement initiatives. For example, working with five other practices in the area to provide extended hours clinics and review the opportunities to provide shared services between the practices.

- The practice results for the Quality Outcomes scheme QOF in 2016/17 were higher than average. Unvalidated data from 2017/18 showed the practice had maintained their high levels of performance at 99% of the total indicators achieved in both the last two years.
- The high level of performance in QOF had been achieved with a lower than average exception rate of 6% compared to the local and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- 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.



# Are services effective?

- 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 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. For example, one of the practice nurses had recently attended a training course on how to support patients with minor illnesses.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

## Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The 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 referrals to weight management, exercise and smoking cessation services.
- 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 and 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 consistently positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results from the national GP survey published in July 2017 showed patients rated the practice higher than average across all aspects of care.

## **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.

## **Privacy and dignity**

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

**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 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.
- The practice provided dispensary services for people who needed additional support with their medicines, for example weekly or monthly blister packs.
- Due to the design of the practice premises access for patients with a physical disability was limited. The GPs and management were aware of this and had made reasonable adjustments to enable wheelchair access to one of the consulting rooms and the treatment room.

### 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 GPs 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, working with the local GP alliance of six practices provided extended hours clinics every weekday until 8pm and on Saturday and Sunday mornings.
- There was online access to order prescriptions and make 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.
- The practice was aware of and supported patients in the local community who were experiencing income deprivation.

### 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.

# Are services responsive to people's needs?

- The GPs and nurses worked with local mental health teams to coordinate care for those patients with complex needs arising from their mental health problems.

## 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.
- Results from the national GP survey published in July 2017 showed patients consistently rated the practice above average for access to appointments and advice. The practice operated a flexible appointment system.

## 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, staff had received additional training to improve the way they interacted with patients following a complaint about staff not communicating appropriately.
- We found one complaint that had not been acknowledged in accordance with the practice complaints process. Whilst records showed the complainant received a timely and full reply to their concerns they would not have known the practice had received and was investigating their concerns.

**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.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The practice was located in a small surgery site where leaders were on duty every day and 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. For example, succession planning among partners was evident with the two partners that joined the practice in 2017 taking a lead on strategy and cross sector working.

## Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear set of values. The practice had a realistic strategy to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice 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 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.
- The practice demonstrated they worked as a team with all staff valued for their contribution to delivering high quality care. Staff were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- 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 interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, there was a monthly structured safety check that was recorded.

## Managing risks, issues and performance

# Are services well-led?

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 review of their prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place to maintain the service if a serious incident affected the ability to deliver services from the premises. There was an up to date business continuity plan.
- The practice implemented service developments and where efficiency changes were made these were led by clinicians to understand their impact on the quality of care.

## Appropriate and accurate information

The practice acted on and had 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 involved patients, 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 was evidence of 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 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.**