

# Droylsden Road Family Practice

## Inspection report

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[www.gtdhealthcare.co.uk/practice/droylsden-road-family-practice](http://www.gtdhealthcare.co.uk/practice/droylsden-road-family-practice)

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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.**

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 Droylsden Road Family Practice on 17 April 2018.

gtd Healthcare took over the practice in February 2017 from an inadequate provider whose registration had been cancelled by the Care Quality Commission (CQC). They have worked on an intense support strategy, both clinical and non-clinical, with the support of the Royal College of General Practitioners (RCGP). This work has involved full reviews of all patients, care plans introduced, a new governance structure and new human resources processes. The RCGP have acknowledged the hard work and commitment of all the staff in the significant improvements made over the past 12 months.

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 used their knowledge of the local community and patient population as levers to deliver high quality and person centred care.
- The practice used innovative and proactive methods to improve patient outcomes. For example, initiating the health passports and well-being plans.
- 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.

We saw several areas of outstanding practice including:

- gtd head office held an annual innovation fund where staff across all localities could bid for funds to improve patient care in their practice. Staff had successfully placed a bid and presented this at the “dragon’s den” style event. The bid was to enable provision of a healthy eating campaign recognising the large deprived population called “5 A Day”. The bid was successful and a locally sourced farm was found to produce 100 bags of pre packed fruit, delivered monthly. Every patient who attended the practice on this day received a fruit package, containing five pieces of fresh fruit and an education leaflet to encourage healthy eating. This had proven extremely successful and had been running since November 2017.
- The practice had a mobile phone service for cancer patients to call in on a special number directly into the practice, provided on the diagnosis of cancer and during their care and treatment. This ensured there would be no problems on receiving immediate support with the practice and ensured the provision of on the day appointment or telephone appointment for the patients.

# Overall summary

**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 was led by a CQC lead inspector. The team included a GP specialist adviser and a practice manager adviser.

## Background to Droylsden Road Family Practice

Droylsden Road Family Practice is the registered provider and provides primary care services to its registered list of 4,416 patients. It is part of and managed by gtd Healthcare, a not for profit social enterprise, and is overseen by Manchester Health and Care Commissioning.

The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; maternity and midwifery services; treatment of disease, disorder and injury; surgical procedures and family planning.

gtd Healthcare provided took over care taking arrangements in February 2017. An intense support strategy both clinical and non-clinical was commenced. gtd Healthcare were supported by the Royal College General Practitioner (RCGP).

Regulated activities are delivered to the patient population from the following address:

55 Crescent Road

Crumpsall

Manchester

M8 9JT

The practice has a website that contains comprehensive information about what they do to support their patient population and the in house and online services offered:

<http://www.gtdhealthcare.co.uk/practice/droylsden-road-family-practice>

The practice is situated in an area at number one on the deprivation scale (the lower the number, the higher the deprivation). People living in more deprived areas tend to have greater need for health services.

# 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. For example, we reviewed an “Environmental Cleanliness Weekly Audit” dated 16 April 2018. Monthly “walk abouts” took place in the practice to ensure standards were maintained, and we saw the last such check took place on the 4 April 2018.
- 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. All staff had received training on safe handling of specimens.

## **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, with clear hand over processes and checks in place for each of these temporary staff. Locum GPs also left a defined list of any patients who had been referred, for the practice to monitor.
- 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 practice had introduced a physician associate into the practice staff to support the clinical leads and who lead on social prescribing for the practice. The role of the physician associate was new to the gtd organisation.
- The practice had introduced the “Health Passport” for all patients living with a long term condition. Each patient was given the passport which contained information on the medicines they were taking, a plan for when they were feeling unwell and health goals. The aim was to empower patients with information about their health and conditions.
- The care records up to date and showed 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.

## Are services safe?

- 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.

### **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.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

**Please refer to the Evidence Tables for further information.**

# Are services effective?

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

## **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 and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The practice had introduced two plans for patients with long term conditions. The “Health Passport” for all patients living with a long term condition and the “Well Being Plan” for patients living with a mental health condition. The plans contained information on what the patient should do if they became unwell or what their future health goals were. They were completed by the clinician and patient together and the patient received a copy to take home. The aim was to empower patients with information about their health and conditions.
- Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff 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. 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.
- 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 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.
- Patients and carers were encouraged to manage their conditions with various information sources to enable them to manage their conditions more effectively. For example: there were action plans for self-management of asthma.
- 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.

Families, children and young people:

# Are services effective?

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the 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.
- 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):

- 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.

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

- The practice had introduced the "Well Being Plan" for all patients living with a mental health condition. Each plan contained information on the medicines they were taking, a plan for when they are feeling unwell and future health goals. The aim to empower patients to manage their health with information about their conditions.
- 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.
- Memory assessment for early diagnosis of Dementia and referral to memory clinic services were available to patients.
- 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 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.
- 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?

- The practice had introduced a physician associate to support the clinical leads. They also took the lead on social prescribing for the practice. The role of the physician associate was new to the gtd organisation however their role as a healthcare professional, who, while not a doctor, worked to the medical model, with the skills and knowledge base to deliver holistic care and treatment within the practice, was proving to be beneficial to patients and a great support to the clinical staff. Each associate had defined levels of supervision from the doctors.
- 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.
- Staff had received IRIS training (IRIS training is an intervention to improve the health care response to domestic violence and abuse).
- 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. 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.

## **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 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. For example, the practice had a clinical and non-clinical cancer champion, and had taken part in The Macmillan Cancer Improvement Programme (MCIP) which is about working together to find new ways that will give everyone a better cancer care experience and ultimately increase survival rates.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with 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.

## **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.
- Educational sessions were designed and presented to patients with great success by the clinician. The most recent session held was Basic Life Support (BLS) which all patients in the practice were offered the opportunity to attend.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.

# Are services effective?

- 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 positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

## **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.
- The practice sent out bowel screening letters to encourage patients to take part in the screening programme.
- Patient information leaflets and notices were available in the patient waiting area, which told patients how to access a number of support groups and organisations. For example, there was a free phone direct to citizen's advice helpline available.
- The practice was part of the Manchester Integrated Neighbourhood Care Team (MINC) which was about working together to support patients who had health or social care problems/concerns/difficulties and would benefit from a multidisciplinary approach to health and social care delivery.
- The practice had a mobile phone service for cancer patients to call through a special number on diagnosis of cancer and during their care, ensuring there would be no problems contacting the practice.
- 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:

- The practice supported patients with long term conditions by using the Expert Patients Programme, which helped patients to regain as much control over their physical and emotional well-being as possible. The practice referred their respective patients to the group.
- The practice provided an in-house phlebotomy (taking blood) service within the practice.
- 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.
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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 five were offered a same day appointment when necessary.

# Are services responsive to people's needs?

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

- The practice used to good affect the Mjog system which sent text messages to patients, informing them of test results and enabling them to make or cancel appointments.
- 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, evening and weekend appointments were also available via the local GP Federation.

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):

- The practice offered patients with poor memory a reminder of their next appointment, by sending a text message or telephone call.
- 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.
- There was a practice leaflet on self-referral to counselling services in the locality and other support in the community to support patients.

## Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practice identified the telephone access into the practice as a concern and resulted in poor comments on NHS choices. The practice was awaiting confirmation of the permanent contact outcome. The new telephone system required a five year contract; something gtd Healthcare could not sign up to until they knew the contract outcome. The new telephone system was pre booked and the outcome of the contract was due to be heard at the end of April 2018.
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## 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.
- All complaints were submitted to head office and discussed at all practice meetings.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the practice handbook.

## Are services responsive to people's needs?

- 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 and all of the population groups 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 offered a well-being intranet page to staff, which offered signposting to services such as childcare schemes and mental health in the work place.
- 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 staff had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe and compassionate care. The GPs and practice manager were visible in the practice.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The head office of gtd Healthcare was also available to offer a full range of clinical and managerial support.

## Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans 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 vision, 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 extremely proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent 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.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- 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

## Are services well-led?

The practice had an overarching governance framework supported by the larger organisation, which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

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

### **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. 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 and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

### **Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- 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, 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 patient participation group (PPG) suggested various events to help the patients in the practice. For example, a basic life support session was suggested and then provided by the practices clinician.
- The PPG chair wrote up the minutes of the meetings and provided the practice with a copy.

## Are services well-led?

- The PPG had a noticeboard was in the waiting room, which encouraged more members to join the 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.**