

Dr Deedar Singh Bhomra

Quality 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 service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Aylesbury Surgery on 07 December 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and staff used an effective system to report significant events. The practice could demonstrate learning from investigations.
- Risks to patients were assessed and well managed with a particularly acute focus on risks associated with vulnerable children and patients with mental health needs.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. A system

was in place to ensure clinical staff maintained an up to date knowledge of changes in national guidance, including from the National Institute of Health and Care Excellence.

- Patients feedback was consistely positive and the practice performed significantly better than local and national averages in the GP Patient Survey.
- Staff had established a clinical audit programme based on the performance of the practice and the needs of its patients and used results to improve services.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns and the practice manager followed up each complaint personally.
- The practice offered a range of appointments to suit patients' needs and to ensure continuity of care.
- The practice had good facilities and was well equipped to treat patients, with adaptations made based on patient feedback.

Summary of findings

- The leadership structure meant staff felt supported and valued, which helped them to give their best. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- There was a consistent and proactive approach to engaging with the local community. This included the implementation of a community health forum to help drive health improvement and provide patients with links to multiprofessional services such as local authority safeguarding and the police. In addition, the service funded and facilitated a monthly communal hot meal for people in the local community.

The areas where the provider should make improvements are:

- The practice should ensure every member of staff has the knowledge and skills to access clinical policies and guidance on the electronic system, including how to

flag and identify patients at risk. There should also be a system in place to ensure staff follow policies and ensure newly implemented guidance is embedded in the service.

- The practice should implement monitoring to ensure the chaperone policy implemented after our inspection was implemented consistently.
- The practice should implement a system to actively identify and support carers within their patient list, as this was at less than 1% at the time of our inspection.
- The practice should encourage patients to engage with national screening programmes for breast and bowel cancer

We found two areas in which the provider must make improvements:

- The provider must ensure the actions resulting from the 2016 infection control audit are fully implemented.
- The provider must ensure storage facilities used for infection control equipment are secured and fit for purpose, with documented evidence of regular reviews to establish effectiveness.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services.

Requires improvement



- There was a lack of specific guidance for staff on the chaperone process and untrained staff sometimes provided this service.
- There was room for improvement in infection prevention and control procedures. This was because cleaning schedules were not detailed and policies were not detailed enough to provide guidance for staff. In addition, action from a previous infection control audit had not been taken and policies for handling biohazard risks and specimens were not adequate.
- Staff did not always follow the policy for uncollected prescriptions, which meant that the prescriber may not be aware that a patient was not taking their prescribed medicine.
- There was an effective system in place for reporting and recording significant events.
- Incidents were investigated and lessons learnt were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again and were given the chance to discuss their concerns in person with the practice manager.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. This included those at risk of female genital mutilation, for whom the practice had implemented additional safeguards.
- Risks to patients were assessed and well managed and risk management processes were improved as a result of learning from incidents, such as a previous IT systems failure.
- Safety policies were readily accessible by staff but not every individual knew how to access them.
- The practice worked with local pharmacy staff to ensure medicines management processes kept people safe and reviewed patients on multiple medicines regularly to identify opportunities to reduce them.

Are services effective?

The practice is rated as good for providing effective services.

Good



Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. This included seven out of 21 exception reporting domains in which the practice was significantly above Clinical Commissioning Group and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance and maintained an up to date knowledge of changes to national guidance and policy.
- Clinical audits demonstrated quality improvement including thorough innovative audits and research developed to meet the needs of the local population. This included unplanned hospital admissions and assessments for pre-diabetes.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was room for improvement in the training of non-clinical staff and in the appraisal process for nurses. After our inspection, the practice implemented changes.
- All staff had undertaken an appraisal in the previous 12 months.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs, including the palliative care team, alcohol and drugs team and community matrons.
- The practice was embedded in the local community and worked proactively with community health organisations and the police in stakeholder forums to discuss and plan for the needs of the local population.
- The practice was proactively working to reduce prescriptions of antibiotics and hypnotics through engagement with patients and health promotion activities.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP Patient Survey was better than local and national averages.
- The practice actively worked to care for the most vulnerable patients and ensured they had access to community and emotional support.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified. For example, links were established with a new alcohol and drug specialist care organisation to help meet the complex needs of patients experiencing addiction.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The environment had been adapted in response to patient feedback, including the provision of more comfortable seating and parking spaces for buggies.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led.

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff spoke positively about the vision, their responsibilities in relation to it and about how they delivered this on a daily basis.
- Staff felt supported by management and the practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework, which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider complied with the requirements of the duty of candour and the senior team encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was represented the practice and also worked to improve community impact, such as through new links with a primary school to improve child health.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels, including in succession planning through GP trainees.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population and actively worked to understand their changing needs.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with complex needs and multiple conditions.
- All patients over the age of 75 had a dedicated, named GP and were offered home visits for routine appointments if needed.
- The practice maintained a register of housebound patients and proactively offered them early prophylactic vaccinations for flu and pneumonia.
- The practice had developed a relationship with a community falls team that enabled patients to receive rapid referrals and risk assessments.
- The practice worked with a local pharmacist to review each patient on four or more repeat prescriptions every six months to identify areas in which medicines could be reduced.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- The nurse practitioner had a lead role in chronic disease management and offered longer appointments and joint reviews with a GP for condition reviews.
- Patients at risk of hospital admission were identified as a priority. A GP trainee had completed a research project that involved a review of unplanned admissions and published a journal paper on their findings. This informed practice policy, which staff used to engage with patients and other health providers to reduce admissions. Conditions that had contributed significantly to emergency attendances, such as musculoskeletal problems, were prioritised for regular patient review.
- Patients who attended hospital in relation to chronic obstructive pulmonary disease were reviewed within two weeks by a GP. This policy was implemented as a result of findings from the research project into hospital attendances.
- Patients had a named GP and a structured annual review to check their health and medicines needs were being met. For

Summary of findings

those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care, including the palliative care team and community matrons.

- Staff demonstrated a consistent approach to empowering patients to learn more about their conditions and health and make lifestyle changes to improve health outcomes. This included targeted information on reducing weight and the risk of pre-diabetes through community engagement.

Families, children and young people

The practice is rated as good overall for the care of families, children and young people and outstanding in the effective domain:

- There were systems in place to identify and follow up on children living in vulnerable circumstances and who were at risk such as children and young people who had a high number of hospital attendances.
- Immunisation rates were significantly better than the Clinical Commissioning Group and national averages for most childhood immunisations.
- The practice offered child health surveillance clinics and worked with parents to improve health through health promotion strategies. The practice also actively sought to empower young people to take charge of their own health through community health forums and engagement with a local primary school.
- Appointments were available outside of school hours and the premises were suitable for children and babies. All children under the age of five were offered same-day appointments.
- The practice had previously taken part in the National Chlamydia Screening Programme for the under 24s and continued to provide sexual health promotion and guidance.
- We saw positive examples of joint working with midwives and health visitors, including through regular meetings to review children at risk.
- The practice had achieved one of the highest cervical screening rates in the locality, at 91% uptake compared with 78% in the Clinical Commissioning Group.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

Good



Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included early morning and evening appointments, which were also offered by phone. Nurses offered early morning blood test appointments that meant patients did not need to risk being late for work.
- The practice offered online booking and medicine requests as well as a full range of health promotion and screening that reflected the needs for this age group. This included lifestyle and healthy eating advice through a community health forum and proactive cardiovascular disease screening for patients not normally considered to be at risk.
- Students were offered the meningitis vaccination before they started university, in line with national guidance.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances, including homeless people and those with a learning disability. The practice offered longer appointments for these patients and offered opportunistic health screening.
- The practice had a named social worker and held quarterly impact meetings to anticipate possible hospital admissions and ensure patients were supported to meet their social needs.
- In response to the needs of the local population, clinical staff had undertaken training to identify and respond to cases of female genital mutilation (FGM). The practice had also established an FGM register to allow liaison with the Clinical Commissioning Group to access specialist resources and support.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice supported vulnerable patients to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies for urgent support.
- The practice provided additional care and resources for vulnerable people in the community. This included working with a church to provide hot meals twice each month and a community health forum to provide health promotion and healthier lifestyle advice to patients and those close to them.

Requires improvement



Summary of findings

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was lower than the national average of 84%. However, we saw evidence of proactive working and health risk management with patients including advance care planning and support for carers.
- The practice worked with a falls prevention service following work that showed a heightened risk of falls in patients living with dementia.
- Staff provided the carers of patients living with dementia with educational appointments following a diagnosis to help them understand the disease and the care options available.
- The practice liaised with community alcohol and drug specialist services to help coordinate care for patients experiencing poor mental health as a result of addiction and in combination with high levels of social and economic deprivation.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice helped patients experiencing poor mental health to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended hospital where they may have been experiencing poor mental health.
- GPs demonstrated a good understanding of the Mental Capacity Act (2005), particularly in relation to young people and people living with a learning disability.

Summary of findings

What people who use the service say

What people who use the practice say

The national GP patient survey results were published in July 2016 and related to data collected between July 2015 and September 2015 and January 2016 and March 2016. The results showed the practice was performing significantly better than local and national averages. 338 survey forms were distributed and 110 were returned. This represented 4% of the practice's patient list.

- 74% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 61% and the national average of 73%.
- 63% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 69% and the national average of 79%.

- 89% of patients described the overall experience of this GP practice as good compared to the CCG average of 82% and national average of 85%.
- 87% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. Patients commented on the personalised service and noted the importance of the practice in the local community. Comments also indicated patients could access appointments when they needed them and a number of individuals commented on the good availability of urgent appointments.

Areas for improvement

Action the service **MUST** take to improve

- The provider must ensure the actions resulting from the 2016 infection control audit are fully implemented.
- The provider must ensure storage facilities used for infection control equipment are secured and fit for purpose, with documented evidence of regular reviews to establish effectiveness

Action the service **SHOULD** take to improve

- The practice should ensure every member of staff has the knowledge and skills to access clinical policies and guidance on the electronic system, including how to

flag and identify patients at risk. There should also be a system in place to ensure staff follow policies and ensure newly implemented guidance is embedded in the service.

- The practice should implement monitoring to ensure the chaperone policy implemented after our inspection was implemented consistently.
- The practice should implement a system to actively identify and support carers within their patient list, as this was at less than 1% at the time of our inspection.
- The practice should encourage patients to engage with national screening programmes for breast and bowel cancer.

Outstanding practice

- There was a consistent and proactive approach to engaging with the local community. This included the implementation of a community health forum to help drive health improvement and provide patients with

links to multiprofessional services such as local authority safeguarding and the police. In addition, the service funded and facilitated a monthly communal hot meal for people in the local community.

Dr Deedar Singh Bhomra

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Deedar Singh Bhomra

Dr Deedar Singh Bhomra is a training practice based at Aylesbury Surgery, Warren Farm Road, Kingstanding, Birmingham B44 0DX.

The practice has level access from the car park and a lift to the first floor. It has a clinical team of one male principal GP, one female salaried GP, one male GP trainee, one nurse practitioner and one practice nurse. The non-clinical team consists of a practice manager, four receptionists and an administration clerk.

The practice is readily accessible for people who use wheelchairs and by parents with pushchairs. A covered, secure parking area for pushchairs is available next to the entrance. A portable hearing loop system is available and there are quiet waiting facilities for patients who find the main waiting area can cause anxiety. Private space is available for breast-feeding.

The practice serves a patient list of 2731 and is in an area of very high deprivation. Of the patient list, 62% are living with a long-term condition and 58% are in paid employment or full time education.

Appointments are from 8am to 6.30pm on Mondays, Tuesdays and Fridays, 8.30am to 2.30pm on Wednesdays

and 8.30am to 7.30pm on Thursdays. Between 8am and 8.30am, patients are directed to an out of hours service and on a Wednesday after 2.30pm the phone system redirects patients to the lead GP's line.

We had not previously carried out an inspection at this practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 December 2016.

During our visit we:

- Spoke with a range of staff.
- Observed how patients were being cared for and talked with the chairperson of the patient participation group.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

Detailed findings

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again in a timely manner.
- The practice carried out an analysis of significant events and had recorded four in the preceding 12 months. Staff used a 'red, amber, green' system to highlight how the investigation and outcome was to be disseminated to staff. For example, 'red' events were always discussed at practice meetings, 'amber' events were discussed if there was learning to be gained and 'green' events were discussed as evidence of good practice. A named person was allocated to each investigation and this person ensured the outcome of the analysis was shared appropriately.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident of an incorrect prescription involving two patients with the same name, a new policy was implemented that required two forms of ID for each patient to receive their prescription. In addition, following an incident that interrupted the service due to an IT failure, staff printed clinic lists three days in advance so they could easily advise patients of problems and interruptions.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff but not all members of staff were aware of how to find them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. GPs attended multidisciplinary safeguarding meetings and worked with local authorities to keep people safe. Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level 3 and had completed an update in the previous 12 months.
- The patient records system highlighted if a patient was known to have a safeguarding need or was subject to a child protection order. Although clinical staff were aware of this system not each person could demonstrate how it worked in practice. For example, one clinical member of staff said they knew there was a flagging system online but could not demonstrate what this looked like.
- Staff demonstrated a proactive approach to exploring a potential safeguarding concern through positive multidisciplinary working with the police and local authority. In addition staff demonstrated compassion and sensitivity in exploring a potential safeguarding risk when they noticed a change in the social status of a parent they knew well. They took action to protect a child from potential harm as a result.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. However, we found staff without specific chaperone training sometimes provided this service. In addition the chaperone policy did not include specific guidance for staff on where they should stand when in the treatment room. After our inspection the practice implemented a policy that meant only clinical staff with appropriate training could act as a chaperone, as well as more specific guidance for staff acting as a chaperone.

Are services safe?

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and flooring and work surfaces were in good condition. Treatment rooms had disposable curtains, which were labelled and all within their safe usage date. Handwashing facilities and personal protective equipment were available in each treatment room and antibacterial gel was available throughout the practice. Staff managed sharps appropriately, including with labelled sharps bins stored according to national guidance. A sharps injuries protocol was in place and had been reviewed in the previous year.
- The practice nurse was the infection control lead and liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Cleaning schedules were readily available but were very basic and it was not possible to identify the level of cleaning undertaken.
- There was room for improvement in infection prevention and control (IPC) practices and procedures. For example, an overarching IPC policy was in place but this was a generic policy that had not been adapted to the specific practice environment. The policy did not identify individual roles or areas of responsibility for staff and it did not include the responsibilities of the IPC lead. Although cleaning schedules were in place there was no evidence of who held responsibility for this. The practice had a biohazard spillage policy in place but not all staff were aware of it. In addition there was no protocol in place for the safe handling of specimens by non-clinical staff, such as when patients brought specimens to reception. After our inspection the practice updated the spillage policy, implemented a specimen handling policy and provided evidence all staff had been trained in its use. In addition, the practice manager arranged for the CCG infection control nurse to deliver training to the practice team.
- The cupboard used to store cleaning chemicals was not secured, which represented a safety risk as it was in an area accessible to patients. After our inspection, the practice manager secured this area with a lock.
- Annual infection control audits were undertaken and action plans were implemented to improve practice. For example, a hand hygiene audit in January 2015 identified areas for improvement in hand washing practice and technique. A Clinical Commissioning Group (CCG) infection control audit in July 2016 found the practice to be 88% compliant with best practice. An action plan had been implemented and most areas had been addressed. For example, hand washing guidance posters were displayed above sinks and a sink was designated for hand-washing only. Other actions for improvement had not been implemented. For example, a cupboard under the stairs was used to store cleaning equipment. The infection control audit found that a designated cleaning cupboard was required that included a sluice hopper for the disposal of waste water and a hand wash basin. Although this had not been implemented at the time of our inspection there was an action plan in place for this to be completed.
- The arrangements for managing medicines including emergency medicines and vaccines kept patients safe. Medicines which required refrigeration were stored according to a cold chain policy and all of the medicines we looked at were within their expiry date. Medicines were stored according to a cold chain policy and all of the medicines we looked at were within their expiry date. Staff recorded the temperature of the medicines fridge daily, which meant they were assured items were stored within the manufacturer's safe storage guidelines.
- Processes were in place for handling repeat prescriptions that included the review of high risk medicines. We looked at the care records of three patients on high risk medicines and found they were reviewed regularly. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines. This had recently included antibiotics and medicines used to treat osteoporosis and rheumatoid arthritis. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Staff used a protocol to check for uncollected prescriptions and conduct a review of the patient before destroying the prescription. However it was not clear that this protocol was used effectively as we found one uncollected prescription at reception that was dated four months previously.

Are services safe?

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There was a system in place to record and log patient safety alerts and we saw evidence this was used effectively. For example when the National Patient Safety Agency issued an alert in relation to specific medicine that could increase the risk of hypertension, the lead GP immediately contacted all patients affected and booked a review with them.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was an up to date health and safety policy that had been adapted to the needs of the practice. The practice had up to date fire risk assessments and carried out regular fire alarm tests. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- Although staff had undertaken fire safety training, they had not undergone regular fire drills or a simulated evacuation. Instead the practice manager had verbally explained how an evacuation would be handled. After our inspection the practice manager arranged a fire drill and training programme with the local fire protection authority.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to an emergency and wall-mounted panic alarms were in every room.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available and oxygen with adult and children's masks. A first aid kit and accident book were available. The practice used national resuscitation guidance in emergencies.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for service providers but not for staff members. A system to ensure information would be available for patients and a plan to continue to deliver care in urgent cases was included. There was not a plan in place for medical emergencies or major incidents in the local area. We spoke with the lead GP about this who told us they would implement a policy.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. NICE guidance was discussed at monthly staff meetings. Each staff meeting had a clinical theme, such as diabetes, which was used to focus on the latest best practice guidance and any national policy changes.
- The practice monitored that these guidelines were followed through with risk assessments, audits and random sample checks of patient records.
- We looked at examples of care and treatment plans for patients with specific conditions, including complex conditions. This included patients with mental health conditions, asthma, heart disease and epilepsy. In each case the treatment plan reflected the latest guidance and had been updated regularly.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. Results from 2015/16 were 96% of the total number of points available.

In the latest data available, from 2014/15, the practice had significantly lower exception reporting in seven of the 21 domains and were similar to national averages in thirteen domains. The practice reported a significantly higher rate of exceptions in atrial fibrillation, at 19% compared to the Clinical Commissioning Group (CCG) average of 14% and the national average of 11%. The principal GP and practice manager acknowledged the wide variation in exception reporting and attributed this to challenges locally with regards to lifestyle, health behaviour and education. The practice demonstrated proactive engagement with patients through health outreach and community work, which aimed to improve patient 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.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from published in 2015 showed:

- Performance for diabetes related indicators was below the national average and CCG average in two out of five indicators and above the CCG and national averages in three indicators. For example, 67% of patients with diabetes had a measured total cholesterol of 5 mmol/l or less compared with the CCG and national average of 51%. In addition, 63% of patients with diabetes had an IFCC-HbA1c reading of 64 mmol/mol or less in the previous 12 months, compared with the CCG average of 79% and the national average of 78%. 88% of patients had a blood pressure reading in the preceding 12 months of 140/180 mmHg or less, compared to the CCG average of 75% and the national average of 78%. IFCC-HbA1c is a measure of the amount of glycated haemoglobin in the blood and is used by clinicians to establish health risks associated with diabetes.
- Performance for mental health related indicators was better than the CCG and national average in two out of three indicators and worse in one indicator. For example, 91% of patients with schizophrenia, bipolar affective disorder or other psychoses had an agreed, documented care plan in the preceding 12 months compared with the CCG average of 89% and the national average of 88%.

The data was available to us at the time of our inspection and included above related to annual data published in October 2015. After our inspection more up to date information was released that related to 2015/16. In this the practice showed a significant improvement in the exception reporting rate, from an average of 5.2% in 2014/15 to 0% in 2015/16.

There was evidence of quality improvement including clinical audit.

- There had been ten clinical audits completed in the previous 12 months, all of which were completed audits where the improvements made were implemented and monitored. For example, the nurse prescriber and trainee GP had completed an audit of patients at risk of

Are services effective?

(for example, treatment is effective)

pre-diabetes as a strategy to reduce the risk of them developing diabetes in the future. They identified 147 patients at risk due to raised blood glucose levels and invited each patient in for further blood tests. Another audit reviewed patients who received hormone therapy as part of cancer treatment to assess the risks and benefit of the prescription and identify alternatives if appropriate.

- The practice participated in local audits, national benchmarking, accreditation, peer review and research. For example, the practice reviewed all cancer diagnoses amongst patients and found their approach to screening had resulted in 98% of cancers in the population group being found by the practice.
- A GP trainee had completed a project to review unplanned hospital admissions. They developed the project based on recent evidence of healthcare reform and reviewed all patients who had attended a hospital emergency department (ED) in the previous six months. The study aimed to look at how patients used EDs and if there were any trends the practice could counteract. For example, the project found 47% of patients attended the ED with a musculoskeletal complaint and that patients who attended the ED most often without seeking a GP appointment did so with a gastrointestinal complaint. The findings were published and helped to inform practice policy on this, which had been updated to include more frequent reviews of admissions. There was evidence reviews led to improved outcomes for patients and a reduced risk of hospital admission. For example, where admission reviews indicated a patient might have attended hospital due to a medicine problem, a GP reviewed their medicine and offered alternative treatment plans where possible.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had a two day induction programme for all newly appointed staff and a two week supernumerary period for clinical staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality according to an established policy. The induction period for each new starter was adapted to their needs and included a period of one-to-one shadowing until they were confident and had completed initial training.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff including from the Royal College of General Practitioners. For example, for those reviewing patients with long-term conditions and in new cancer guidelines. Nurses demonstrated they maintained up to date clinical training and updates and the GP trainee gave positive feedback about their opportunities for training and development.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training that included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. However, the practice manager conducted nurse appraisals, which meant there was no clinical input into the process. We discussed this with the principal GP and the practice manager who implemented a new appraisal system for nurses. As a result the principal GP was due to conduct nurse appraisals with the practice manager from January 2017.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months and the practice manager had specific training for this.
- All staff received training that included safeguarding, fire safety awareness, basic life support, infection control and information governance. Staff had access to, and made use of, e-learning training modules and in-house training and all members of staff had completed annual updates. In addition, staff undertook role-specific training and updates. This included dementia awareness, end of life care, Legionnaires disease and domestic violence awareness. One nurse had undertaken a diploma in diabetes and another nurse had undertaken specialist training in chronic obstructive pulmonary disease and asthma. Although training records indicated staff were up to date, it was not

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always clear how effective online training was. For example, one member of staff could not remember any details of their fire training or information governance training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. The practice shared critical information such as do not attempt resuscitation authorisations with out of hours and emergency services.
- The practice shared relevant information with other services in a timely way, including when referring patients to other services. Community midwives had access to the electronic patient records system, which helped to provide continuity of care.
- The lead GP worked with a local hospice to provide rapid access and care for patients who needed end of life care. The practice manager acted as the community liaison officer for the hospice and printed information was available on the service in multiple languages.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice actively sought out relationships with other organisations that would benefit patients. For example, a stakeholders meeting held in November 2016 included staff from community health services, a chaplain, a police officer with responsibility for safeguarding and vulnerable people, a counter-terrorism officer and a patient who lived in a local care home. This team led a forum for local residents to discuss their experiences and identify how they could inform developments in the practice.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Most staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. One clinical member of staff said they did not know the principles of this and would need to look it up before acting on it. Staff were trained in the Gillick competencies and Fraser guidelines in relation to the rights of children.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. This included with young people living with a learning disability.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and recorded the outcome of the assessment.
- Clinical staff had up to date consent training and had developed a consent recording form for procedures such as fitting coils and implants. This enabled staff to document when verbal consent had been obtained.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation received individualised support to access specialist services.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.
- The practice had an automated message on the phone service to advise patients that the antibiotics policy was to prescribe these only when necessary for conditions that would not resolve themselves. This was in response to comparatively high rates of antibiotic prescribing. For example, the practice prescribed 0.41 antibacterial prescription items per patient group as defined by the NHS Business Services Authority. This compared to a CCG average of 0.28 and a national average of 0.27. These data related to 2014/15 and the practice had worked to change the mindset of patients who traditionally sought

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out antibiotics unnecessarily by providing health promotion support. The practice audited antibiotic prescribing between October 2015 and September 2016 and noted a 54% reduction in the rate of prescribing.

- In 2014/15 prescribing of hypnotic medicine was higher than the CCG and national averages. For example, the practice prescribed 0.56 hypnotics per patient group as defined by the NHS Business Services Authority. This compared to a CCG average of 0.28 and a national average of 0.26. In response the practice stopped repeat prescriptions for hypnotics and invited each patient to attend the practice to reduce their reliance on the medicine. This approach demonstrably improved practice, as evidenced by 2015/16 data, which showed the practice prescribed in-line with CCG and national averages and achieved 3.5% lower antibiotic prescribing than these averages.
- The practice had created a community health forum that aimed to improve the health of the local population through outreach and health promotion programmes. The practice had established a relationship with the local police force, who provided an officer one day per week to be based in the practice and act as a liaison for patients. In addition the practice had applied to the local authority for a road closure to be able to organise a walk for all patients and their friends as part of the focus on health promotion.

The practice's uptake for the cervical screening programme was 91%, which was significantly higher than the CCG average of 78% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening although rates were lower than national and CCG averages:

- 60% of females aged 50-70 had undergone breast cancer screening in the previous 36 months compared with a CCG average of 69% and a national average of 72%.
- 62% of females aged 50-70 had undergone breast cancer screening in the previous six months compared with a CCG average of 68% and a national average of 73%.
- 39% of people aged 60-69 had undergone bowel cancer screening in the previous 30 months compared with the CCG average of 50% and the national average of 58%.
- 32% of people aged 60-69 had undergone bowel cancer screening within six months of invitation compared with the CCG average of 50% and the national average of 58%.

The practice used health improvement events, opportunistic discussions during appointments and annual health reviews to encourage patients to take up screening. The data above was available at the time of our inspection and we saw an improvement in bowel cancer screening in data available in March 2017:

- 41% of people aged 60-69 had undergone bowel cancer screening in the previous 30 months compared with the CCG average of 50% and the national average of 58%.
- 46% of people aged 60-69 had undergone bowel cancer screening within six months of invitation compared with the CCG average of 48% and the national average of 56%.

Childhood immunisation rates for the vaccinations given were significantly higher than CCG and national averages and the practice exceeded the national 90% target in all vaccinations for children under the age of two with an average of 97%. For MMR doses for children under the age of five, the practice achieved 100% coverage, which was better than both CCG and national averages.

The practice manager coordinated a quarterly health and engagement community forum newsletter. The newsletter aimed to provide patients and their relatives and friends with information to improve their health, written by practice staff with an interest in health promotion. This included advice on exercise and healthy eating and guidance from the chairperson of the patient participation group on long-term health.

The practice had proactively engaged with a local primary school to promote healthy living amongst children. This

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included sponsoring an Easter bonnet trophy and conducting tours of the practice with groups of children. Children were able to discuss their ideas for healthy living with practice staff, who discussed the dangers of smoking as a future prevention strategy as well as the importance of

exercise and eating fruit and vegetables. The practice also planned to help children understand the GP environment and reduce their anxiety and answer common myths. The programme had been established and the first practice visit was scheduled for March 2017.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with the chairperson of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy had always been respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 99% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 97% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.

- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

The practice manager monitored feedback submitted to the NHS Choices website. The practice had received an average rating of 3.5 out of five based on nine recent reviews. Patients who left comments received a reply and the practice manager responded to negative feedback by offering to meet the person who commented.

Care planning and involvement in decisions about care and treatment

Patients noted they felt involved in decision making about the care and treatment they received and we saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 97% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Translation services were available for patients who did not have English as a first language as well as translators for British Sign Language. We saw notices in the reception areas informing patients this service was available. In response to an increase in patients from specific countries, the practice proactively identified translators in these languages in advance.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

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. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (0.7% of the practice list) and offered them annual healthchecks and first access to winter flu vaccinations. Written information was available to direct carers to the various avenues of support available to them. The practice recognised the relatively low rate of registered carers and

demonstrated a proactive approach in identifying more patients with such responsibilities. For example, a display area in the waiting room included information to encouraged carers to come forward and practice community health events included encouragement for carers to work with the practice to ensure their own wellbeing.

If families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours to meet the needs of commuters, including early mornings and evenings.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A nurse offered a travel clinic for vaccinations.
- There were disabled facilities, a hearing loop and translation services available.
- There was a lift in the practice with capacity for a wheelchair or pushchair and all treatment rooms were accessible. A disabled-access toilet was available and the practice had a wheelchair patients could use whilst on site.
- The lead GP had a special interest in palliative care and ensured patients received a responsive, individualised service. For example, links were in place with a local hospice that could provide dedicated care for the practice's patients and the practice monitored performance by the number of patients who died in the place of their choice.
- The practice demonstrated a commitment to improving the lives of people in the local community. For example, the practice manager and lead GP had established a relationship with a local church to provide hot meals to people on the last Sunday of each month. The practice funded this and between 80 and 200 people attended each meal.
- The practice had established links with alcohol and drug addiction services in the local community to help support patients experiencing addiction. This included patients with mental health needs and multidisciplinary work with the local authority to support patients who were living with social or economic deprivation.

Access to the service

The practice was open from 8am to 6.30pm on Mondays, Tuesdays and Fridays, 8.30am to 1.30pm on Wednesdays and 8.30am to 7.30pm on Thursdays. Between 8am and 8.30am, patients were directed to an out of hours service and on a Wednesday after 1.30pm the phone system redirected patients to the lead GP's line.

In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments and home visits were available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was significantly higher than local and national averages.

- 88% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 79%.
- 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 61% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- Whether a home visit was clinically necessary. One patient told us they had been proactively offered a home visit because the GP knew their partner was ill and was concerned a visit to the practice would add additional pressure on them.
- The urgency of the need for medical attention. Reception staff had undertaken training to identify when a patient needed emergency care.

The practice had established a relationship for ambulatory care and triage with the local NHS ambulance provider. This meant ambulance crews could call the GP during designated times for patient review, to avoid an unnecessary hospital admission.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Are services responsive to people's needs? (for example, to feedback?)

- There was a designated responsible person who handled all complaints in the practice although not all staff were aware of the process to follow if a patient made a complaint. For example, one member of staff said they would tell patients to put a note in the comments box in reception to make a complaint.

We looked at all seven complaints received between February 2016 and December 2016. In each case the practice investigated the complaint and ensured the

complainant was kept up to date with progress. Lessons were learnt from individual concerns and complaints to improve the quality of care. For example, the practice manager met with patients to explain the appointment system and how they could best access appointments that suited them. In addition, the practice worked with patients with mental health needs to help them navigate the appointment system.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement focused on the local community as a 'family' and that promoted cohesion.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. All of the staff we spoke with said they felt involved in the practice vision and its future.
- The lead GP had succession planning in place with a view to increase staffing to five GPs alongside an increase in the list size.

Governance arrangements

The practice had an overarching governance framework, which supported the delivery of good quality clinical care. However, this did not always ensure risks were fully managed or that staff were able to take full responsibility in their respective areas of responsibility:

- There was a clear staffing structure although staff were not always aware of their own roles and responsibilities, including in chaperone duties and in relation to the Mental Capacity Act.
- Practice specific policies were available to all staff but were not always implemented, including in relation to infection control and prescription management.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements in relation to clinical care and community engagement.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not always robust or consistent, for example in relation to infection prevention and control.

Leadership and culture

On the day of inspection the senior team in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- The practice held monthly team meetings and all of the staff we spoke with said they felt there was a positive team-working atmosphere.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. All staff told us they felt respected and supported and said this helped them to give their best.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG had

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

seven core members who met quarterly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice provided more comfortable chairs in the waiting room following feedback. In addition the PPG wanted to raise funds for an outside garden to make the environment more attractive. In response the practice manager organised a sponsored fun run in the local community. The chairperson of the PPG had led a discussion at a community health forum event held in the practice as a strategy to engage patients who were historically challenging to reach with health improvement messages.

- The PPG wanted to develop the group to ensure they were more representative of the patient population,

particularly by attracting younger members to join. In response the practice manager developed a new relationship with a local primary school as a strategy to engage younger people in the community.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area, including through more targeted support for those experiencing addiction and urgent referrals for patients at risk of female genital mutilation.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered provider did not have consistent, safe processes in place to manage the risks associated with prevention control in the surgery. This was because an action plan from a 2016 annual infection control audit had not been fully addressed, including through the provision of a sluice hopper for the disposal of waste water and a hand wash basin in the area used to store infection control equipment.</p> <p>The provider must ensure the actions resulting from the 2016 infection control audit are fully implemented.</p> <p>The provider must ensure storage facilities used for infection control equipment are secured and fit for purpose, with documented evidence of regular reviews to establish effectiveness.</p> <p>This was in breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>