Central Medical Centre

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 Central Medical Centre on 10 November 2015. 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 an effective system in place for reporting and recording significant events.
- Most risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Data showed patient outcomes were average or above for the locality. Audits had been carried out with evidence that they were driving performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice used innovative and proactive methods to meet patients' needs, specifically tailoring their services for patients from vulnerable groups.
- Information about services and how to complain was available and easy to understand and a range of patient information was available in Tamil.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. Patients were able to get routine appointments quickly.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Policies and procedures were not always easily accessible for staff but there was evidence that they were updated to reflect changes in practice systems.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on and they had an active Patient Participation Group (PPG).
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw several areas of outstanding practice:

Summary of findings

- The practice had tailored its service and there were innovative approaches to promoting patient education, especially in vulnerable groups. The practice had developed patient education information for a range of conditions in Tamil, including a diabetes book and provided new patient health checks to promote self-management. The practice reported they had shared their information leaflets with other local health services to support Tamil patients.
- The practice had tailored its services for vulnerable patients; staff were able to speak twelves languages, chaperones that spoke Tamil were available and information was available in Tamil in the patient waiting area including information for bereavement support.
- The practice had an in-house pharmacist and reviews for patients over 75 were completed jointly by the practice nurse, GP and practice pharmacist where indicated. Joint home visits were undertaken for housebound patients over 75 to complete their care plans, to ensure that patients' holistic needs were assessed. The pharmacist was involved with ensuring that the medicines that patients from overseas were taking were replaced with appropriate UK equivalents.

The areas where the provider should make improvement are:

- Ensure that emergency equipment includes access to defibrillator pads for children.
- Ensure that the practice has a updated record of assessed risks relating to health and safety of the premises including those related to asbestos and portable appliance testing.
- Ensure the practice has systems in place to monitor staff training effectively, including mandatory training requirements and ensure that practice policies and procedures are easily accessible for staff.
- Ensure that minutes are recorded for partnership meetings so actions can be monitored.
- Consider how to improve patient satisfaction regarding access to appointments as indicated in the GP patient survey.

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice although it was not always clear if all actions were followed up.
- When there are unintended or unexpected safety incidents, people receive reasonable support, truthful information, a verbal and written apology and are told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Most risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data showed patient outcomes were at or above average for the locality and the practice performed highly in relation to childhood immunisation rates and supporting those with learning disabilities.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the knowledge and experience to deliver effective care and treatment and there was a large skill mix amongst clinical staff.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams on a monthly basis to understand and meet the range and complexity of people's needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice in line with others for several aspects of care.
- However, feedback from patients about their care and treatment from comments cards, compliments and patients we spoke with was consistently and strongly positive.

Summary of findings

- All 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 with information about bereavement support available in Tamil.
- We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- It 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 had tailored its service and there were innovative approaches to promoting patient education, especially in vulnerable groups. The practice had developed patient education information for a range of conditions in Tamil, including a diabetes book and provided new patient health checks to promote self-management.
- The practice had tailored its services for vulnerable patients; staff were able to speak twelve languages, chaperones that spoke Tamil were available, information was available in Tamil in the patient waiting area.
- The practice pharmacist worked closely with the nurses and GPs providing joint visits for over 75s where required and they were involved with ensuring that the medicines that patients from overseas were taking, were replaced with appropriate UK equivalents.
- The practice implemented suggestions for improvements and made changes to the way it delivered services following feedback from patients, for example, improving telephone access.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. Routine appointments were available within 24 hours. However, patients reported that they were sometimes kept waiting when appointments were delayed.
- People were able access appointments and services in a way and at a time that suited them; the practice offered extended hours three evenings per week and every Saturday morning.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

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

- It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. 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 was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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

Good

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population including avoiding unplanned admissions care plans and over 75s health checks with a GP, practice nurse and practice pharmacist in the practice or at home for those who were housebound.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were above Clinical Commissioning Group (CCG) and national average, for example for those with atrial fibrillation and osteoporosis.
- The percentage of people aged 65 or over who received a seasonal flu vaccination was 65% for 2014/15 and 63% for 2013/14 which was lower than national average. However, the practice had worked to promote uptake via offering a Saturday flu clinics.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management, specifically for patients with diabetes and respiratory conditions.
- Patients at risk of hospital admission were identified as a priority and were placed on the practice's avoiding unplanned admissions register.
- Those with two or more long-term conditions were also placed on a practice register. The practice worked to provide these patients with a care plan.
- The practice monitored patients with uncontrolled diabetes and provided patient information in Tamil due to the higher prevalence of diabetes in the Asian population.
- Longer appointments and home visits were available when needed.
- All these patients had access to a structured annual review to check that their health and medication needs were being met.

Summary of findings

- For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary approach to care and there was evidence that these monthly meetings were being used effectively to monitor and improve outcomes for patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place 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 A&E attendances.
- Data for 2014/15 showed that the practice were the second highest performing practice in the Clinical Commissioning Group (CCG) for the five in one vaccine for those under 12 months, achieving 98%.The practice were the highest performing in the CCG for the pre-school booster, achieving 92% compared with CCG average of 63%, despite the practice having a higher than average number of children under 5 years. The practice promoted uptake by monitoring those who missed immunisations and proactively asked parents and guardians to bring the immunisation records to new patient appointments due to the large number of patients from abroad.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided a winter children's emergency clinic in 2014 to reduce accident and emergency attendances.
- The practice offered shared care midwifery services and a midwife visited the practice every two weeks.
- A full range of family planning services were offered.
- The practice offered health promotion for this population group including chlamydia screening.

Working age people (including those recently retired and students)

Good

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

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.
- Extended hours were offered three evenings a week and patients were able to access Saturday morning appointments.
- The practice was proactive in offering online services for appointments and prescriptions as well as a full range of health promotion and screening that reflected the needs for this age group.
- A full range of family planning services were offered.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding 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, housebound patients, vulnerable adults and children and those with a learning disability.
- It offered longer appointments for people with a learning disability.
- It provided annual health checks for people with a learning disability and 100% of 17 eligible patients had received a review. The practice met with the community learning disabilities nurse on an annual basis.
- One of the non-clinical staff members was able to communicate using sign language.
- The practice were pro-active in making use of new patient health checks to screen new patients with complex conditions, due to the large number of new patients from abroad and due to the high prevalence of diabetes, especially in their Asian population. They had completed 876 new patient checks in 2014/15.
- There was significant support available for patients with language barriers. The practice had recognised that the majority of their practice population were from Tamil and Sri Lankan backgrounds. There were notices in Tamil in the waiting area and the website could be viewed in other languages. The practice provided a patient information leaflet in Tamil for new patients and information relating to bereavement support was available in Tamil.

Summary of findings

- Twelve different languages were spoken amongst practice staff including Tamil, but a translation service was available when required. Two non-clinical staff members who spoke Tamil had been specifically trained to be a chaperone for this patient population.
- The practice had tailored its service to ensure patient education was a priority, especially in vulnerable groups. The practice had worked with its staff to develop a range of patient information leaflets in Tamil. Information including detailed leaflets for diabetes, dementia and breast feeding. The practice reported they had shared their information leaflets with other local health services to support Tamil patients.
- The practice had a high prevalence of diabetic patients; double the expected prevalence for the practice list size. This was due to a high incidence of diabetes in the Asian population. The practice had published a book about diabetes in Tamil, to specifically target those with a risk of uncontrolled diabetes. The practice had also trialled a Saturday morning education session for Tamil patients for long-terms conditions such as diabetes.
- The practice were able to signpost patients to a local temple which provided social support, access to Tamil families in the area, and some health education from Tamil speaking consultants in radiology and mental health and other invited speakers.
- 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 in normal working hours and out of hours.
- The practice regularly worked with multi-disciplinary teams monthly in the case management of vulnerable people and the practice attended quarterly child protection meetings.
- The practice held a clinical meeting monthly which included a discussion of patients who had attended Accident and Emergency (A&E), to assist in identifying the most vulnerable patients who had frequent A&E attendances.

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).

- 96% of people experiencing poor mental health had received an annual physical health check and 70% of those with dementia had received an annual review.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Meetings were held twice yearly with local community mental health teams to discuss patients on the register.
- It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.
- It was proactive in case finding and diagnosing dementia and had increased incidence of dementia over the past three months.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice hosted a psychological therapy service one day a week and were able to refer patients to this service.
- Staff had a good understanding of how to support people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015. The results showed the practice was performing in line with local and national averages. There were 439 survey forms distributed 106 forms were returned. This is a response rate of 24.1%.

- 76% describe the overall experience as good compared with a Clinical Commissioning Group (CCG) average of 79% and a national average of 85%.
- 52% find it easy to get through to this surgery by phone compared with a CCG average of 60% and a national average of 73%.
- 70% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.
- 34% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 50% and a national average of 60%.
- 79% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 81% and a national average of 85%.
- 72% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.
- 61% describe their experience of making an appointment as good compared with a CCG average of 66% and a national average of 73%.
- 41% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 55% and a national average of 65%.
- 28% feel they don't normally have to wait too long to be seen compared with a CCG average of 47% and a national average of 58%.
- 56% would recommend the practice compared with a CCG average of 71% and a national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards which were all positive about the standard of care received. Patients felt that the reception staff were friendly and helpful and that GPs were patient and took the time to listen to them. Patients reported that the practice provided an excellent service, particularly for Tamil patients.

We spoke with 10 patients during the inspection and one member of the practice's Patient Participation Group (PPG). All patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Comments cards received and patients we spoke with reported that it was easy to get appointments, however when they attended the practice, appointments were frequently delayed.

Central Medical Centre

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 advisor, a second CQC inspector, a practice manager specialist advisor and an Expert by Experience.

Background to Central Medical Centre

Central Medical Centre provides primary medical services in Merton to approximately 8400 patients and is one of 24 practices in Merton Clinical Commissioning Group (CCG). The practice population is in the fifth least deprived decile in England.

The practice population has a lower than CCG average representation of income deprived children and older people. The practice population of children, older people and those of working age are in line with local and national averages. Of patients registered with the practice, 59% are Asian and Asian British; specifically the practice has a high Sri Lankan Tamil population. Forty per cent are White British and White European. The practice has double the expected prevalence of diabetes for the patient list size due to the incidence of this in the Asian population.

The practice operates from an adapted residential property. All patient facilities are on the ground floor and are wheelchair accessible and the practice has access to seven doctors' and nurses' consultation rooms and one treatment room. The practice team at the surgery is made up of one full time male lead GP who is a partner and one full time female GP who is a partner, one full time male salaried GP, one part time male salaried GP and three part time female salaried GPs. In total the GPs provided 44 sessions. The practice team includes one full time female advanced nurse practitioner, one part time female practice nurse, one part time male practice nurse, one part time male health care assistant and a part time pharmacist employed by the practice. The practice team also consists of a practice manager, eight administrative staff and nine reception staff members.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice provides teaching to medical students.

The practice reception and telephone lines are open from 8am to 8pm Monday, Tuesday and Wednesday; 8am to 6.30pm Thursday and Friday and 9.30am to 12.30pm on Saturdays. Appointments are available between 8.30am and 6.30pm every day. Extended hours surgeries are offered from 6.30pm to 8pm Monday, Tuesday and Wednesday and 9.30am to 12.30pm on Saturday.

The practice has opted out of providing out-of-hours (OOH) services to their own patients between 6.30pm and 8am and directs patients to the out-of-hours provider for Merton CCG.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening services, family planning services, maternity and midwifery services and treatment of disease, disorder or injury.

The practice was previously inspected on 14 May 2014 as part of a pilot, but was not rated. The provider was found to be compliant with the relevant regulations.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 November 2015.

During our visit we:

- Spoke with a range of staff including six reception and administrative staff, the practice manager, three GPs, the advanced nurse practitioner and the health care assistant and we spoke with 10 patients who used the service and one member of the practice's Patient Participation Group (PPG).
- Observed how people were being cared for and talked with carers and/or family members.
- Reviewed the personal care or treatment records of patients.
- Reviewed 36 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 are provided for specific groups of people and what good care looks 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.

Good

Are services safe?

Our findings

Safe track record and learning

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

- There was a significant event policy and all staff that we spoke to knew to report significant events to a member of clinical staff, the practice manager and document the event on a significant event form.
- Significant events were documented and discussed in quarterly meetings involving clinical and non-clinical staff.
- The practice carried out a thorough analysis of the significant events.

We reviewed the three significant event reports and three sets of minutes from significant event meetings. Although these contained lessons learnt and solutions to address the issues raised, there was no documented evidence to show that the suggested actions had been completed and reviewed. The practice had identified three significant events related to repeat prescribing. We found evidence that the practice's prescribing policy had been updated as a result and that a meeting had been held specifically to share the new prescribing policy and procedures with relevant staff.

When there are unintended or unexpected safety incidents, the practice told us that people receive reasonable support, truthful information, a verbal and written apology and are told about any actions to improve processes to prevent the same thing happening again.

The practice had a system in place to review safety alerts sent to the practice and kept a record of alerts received, however it was not always clear if they had been actioned. The practice manager received alerts by email and told us that they would email these to the GPs and provide them with printed copies. GP staff told us that medicines alerts were then passed to the pharmacist who would undertake a review of patient records where appropriate.

Overview of safety systems and processes

The practice had processes in place to keep people safe and safeguarded from abuse, however some areas lacked a clear system. For example:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The practice had child and adult safeguarding policies in place however these required updating. All staff were very clear about their responsibilities, knew who the safeguarding leads within the surgery were and knew to contact these staff members if they had any safeguarding concerns. All clinical staff had completed child Safeguarding to level 3. All non-clinical staff were trained to at least Safeguarding level 1 with the exception of one staff member who completed this shortly after the inspection. A number of clinical and non-clinical staff had not completed Safeguarding training for adults, but this was also undertaken after the inspection. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. The practice had clear systems for monitoring children at risk; they kept a register of those on the child protection register and also a register of children at risk. They also kept a register of vulnerable adults who were at risk and all these patients were discussed during the integrated team meetings. Quarterly child protection meetings were also held.
- A notice in the waiting room advised patients that staff would act as chaperones, if required, although this notice was not available in Tamil. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The nurse practitioner was the infection control clinical lead. There was an infection control policy and supporting procedures in place and staff had received up to date training from the nurse practitioner, relevant to their roles. Annual infection control audits were undertaken, the last in May 2015 and we saw evidence that action was taken to address any improvements identified as a result.
- There were arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). We were informed that the in-house practice pharmacist highlighted patients for GPs to review by conducting searches; identifying medicines that may be inappropriate; monitoring prescribing and they also had

regular discussions with staff to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice had recently updated their antibiotic prescribing policy and were aware of their antibiotic prescribing performance. Prescription pads were securely stored. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- We reviewed 4 personnel files and found that appropriate recruitment checks had been undertaken prior to employment for three of these staff members. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, evidence of an updated criminal records check was not in place for the practice pharmacist who had been employed at the surgery for some years and worked directly with patients. The practice obtained a copy of this after the inspection.

Monitoring risks to patients

The majority of risks to patients were assessed and managed adequately.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and carried out regular fire drills.
- When we inspected the premises there was no evidence that portable appliance testing had been carried out, which was an action from a previous fire risk assessment. However shortly after the inspection we saw evidence that this had been completed and no concerns were identified. All clinical equipment had been subject to calibration testing within the previous 12 months.
- The practice also had a control of substances hazardous to health policy and infection control risk assessment in place.
- Legionella testing had been completed in September 2014 and in November 2015 and the practice undertook regular water temperature checks. Given the age of the building we asked to see an asbestos assessment for the premises. The practice did not have evidence of a previous asbestos risk assessment. Immediately following the inspection, an asbestos check was undertaken and we were shown evidence this had been completed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. A number of regular locum GPs were used to ensure that an adequate number of sessions were offered. This meant that locum staff were familiar with the practice's systems and processes.

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 which alerted staff to any emergency.
- All clinical and non-clinical staff had received annual Basic Life Support Training within the last twelve months.
- The practice had a supply of emergency medicines available in the treatment room.
- The practice had oxygen on the premises with adult and children's masks. The practice also had a defibrillator on site but only had defibrillator pads for adults. There was also a first aid kit and accident book available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice manager also kept a copy of this externally to the practice premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line 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 peoples' needs. The practice had access to NICE guidance and local guidance via a recently established Clinical Commissioning Group (CCG) system and one of the partners was the pathway champion for this project.
- The GPs had identified roles for leading in long-term conditions such as diabetes, dementia and Chronic Obstructive Pulmonary Disease (COPD) and also leading in areas such as family planning and women's' health. The practice nurses, which included an advanced nurse practitioner, assisted with assessing needs of patients. The nurses had particular specialist skills in supporting diabetic patients, as the practice had a high incidence of diabetic patients.

From all medical records we reviewed, the practice was found to be following best practice guidance and patients' needs were effectively assessed with the use of annual review templates and care plans where relevant. Care plans we viewed included those for patients most at risk of admission to hospital, care plans for those with two or more long-term conditions and care plans to support patients over the age of 75s. The practice had an in-house pharmacist and reviews for patients over 75 were completed jointly by the practice nurse, GP and practice pharmacist. Joint home visits were undertaken for housebound patients over 75 to complete their care plans, to ensure that patients' holistic needs were assessed. The practice also actively used advanced care planning for patients with dementia and from medical records were saw, appropriate advanced decisions had been discussed and documented.

There was evidence from all care plans we viewed that they were individualised and patient-centred and we were shown how the practice ensured care plans were signed by patients and patients received a copy of these.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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.) The most recent published results were 95.4% of the total number of points available, with 5.2% exception reporting. This was above the Clinical Commissioning Group (CCG) and national averages of 94.4% and 93.5% respectively. This practice was not an outlier for any QOF (or other national) clinical targets.

Data from 2014/15 showed:

- Performance for diabetes related indicators was below or in line with local and national averages. For example, 69% of patients had well-controlled diabetes, indicated by specific blood test results, compared to the CCG average of 73% and the national average of 78%. The practice reported they had double the expected prevalence of diabetes in their practice population, with the majority of patients from Tamil backgrounds. The practice recognised that diet and lifestyle issues resulted in lower achievement of well-controlled diabetes, however they had put strategies in place to promote education and self-management for patients. The number of patients who had received an annual review for diabetes was 89% which was similar to the CCG average of 89% and national average of 88%.
- The percentage of patients over 75 with a fragility fracture who were on the appropriate bone sparing medication was 100%, which was above national average of 93%.
- The percentage of patients with atrial fibrillation treated with anticoagulation or antiplatelet therapy was 100%, which was above the national average of 98%.
- Performance for mental health related indicators was above the CCG and national averages; 96% of patients had received an annual review in compared with CCG average of 92% and national average of 88%.
- The number of patients with dementia who had received annual reviews was 70% which was lower than

Good

Are services effective?

(for example, treatment is effective)

the CCG and national average of 84%, however the practice provided evidence that they had completed 17 reviews for 21 patients on the practice's register, which was 81%.

- The number of patients with Chronic Obstructive Pulmonary Disease (COPD) who had received annual reviews was 91% compared with CCG average of 93% and national average of 90%.

The practice had also monitored patients on other practice registers and completed annual reviews, health checks and care plans for these patients.

For example:

- The practice had care plans for the most at risk patients on the avoiding unplanned admissions register, which was 2.3% of the practice population. The practice provided next day telephone consultations when any of these patients had been discharged from hospital, where appropriate.
- The practice were involved in a local CCG initiative to monitor those with two or more long-term conditions and produced care plans for them. The practice had identifed 6.8% of the practice population for this register.
- The practice had identified that their prevalence of dementia was low and they had increased the number of patients diagnosed with dementia from 25 to 29 between July 2015 and October 2015.

Clinical audits demonstrated quality improvement:

- There had been five clinical audits undertaken in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. One of these audits was in relation to the practice's antibiotic prescribing performance as they were higher prescribers of specific types of antibiotics compared to others in the CCG area. A clear action plan had been set up following the initial audit which included the development of a self-care template which was given to each patient, to educate them about the treatment that was required for different infections. Improvement in prescribing had been demonstrated in the re-audit results.
- The practice had undertaken four audits that were not yet completed. A clinical audit currently underway was an audit of new patients with borderline scores for diabetes-specific blood tests, who had no diagnosis of diabetes in their records. The practice had undertaken this audit in response to their lower QOF achievement for 2014/15 for this outcome and also due to the higher prevalence of diabetes in their patients.
- Other audits had been undertaken to improve accuracy of record keeping for dementia and diabetes patients and ensure accurate diagnosis recorded on medical records.
- The practice undertook audits to monitor effectiveness and safety of diagnostic and treatment techniques, including those for contraceptive and cervical screening procedures.
- A number of medicines audits had been completed by the practice pharmacist including an audit of insulin injection pens to ensure patients were monitoring expiry dates of these.

The practice frequently engaged in benchmarking against local and national performance. One of the partners was the CCG lead and attended meetings where benchmarking data was discussed, such as referral rates. The practice pharmacist led on reviewing the practice performance from prescribing data.

Effective staffing

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

- The practice had an induction policy and folder and induction checklists were present in most newly recruited staff files. Non-clinical staff reported they had experienced a thorough induction programme that covered such topics as basic life support, safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Induction arrangements included training to use the practice computer systems effectively.
- Clinical and non-clinical staff received training that included: safeguarding children and adults, fire procedures, basic life support and information governance awareness. Clinical staff had training in the Mental Capacity Act 2005. Staff had access to and made

use of e-learning training modules and in-house training. We were shown that all staff were in the process of completing information governance e-learning modules.

- Role-specific update training for clinicians included training for diabetes, COPD, smoking cessation, cervical screening and immunisations. The practice had wide skill mix to ensure effective staffing amongst clinical staff. One of the GPs had a special interest in family planning and was an accredited trainer for contraceptive techniques. The nurse practitioner was a nurse prescriber and led on the emergency daily clinics in the practice. The practice employed a pharmacist, to work jointly with clinicians.
- Staff personnel and training records was not clearly organised, to enable the practice to monitor staff training effectively.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Most staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. The practice nurse attended the local practice nurse forum to seek peer support.
- All staff had received appraisals annually.

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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. The practice had good systems in place to ensure that test results were dealt with quickly.

We saw evidence that multi-disciplinary team meetings with district nurses, social services and the palliative care team took place on a monthly basis and that care plans were routinely reviewed and updated. At the monthly meeting, the practice reviewed patients on the practice's palliative register, the practice's avoiding unplanned admissions register and discussed other at risk patients known to community nursing and social services teams. The practice kept detailed minutes of discussions and actions due. In addition, the practice ran a monthly clinical meeting to discuss accident and emergency (A&E) attendances and hospital admissions so at risk patients could be monitored.

The practice also met with the community learning disabilities lead nurse annually and met with the local mental health team specialists twice a year and we were shown minutes of these meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- Written consent was obtained for some contraceptive procedures and for joint injections and this was scanned onto the patients' records.
- The process for seeking consent was monitored through accreditation audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

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

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation, those over 75 and those with a learning disability. Patients were then signposted to the relevant service.
- A healthy lifestyle advisory service was available on the premises once weekly, which included obesity management, alcohol advice and smoking cessation advice. Clinicians also provided lifestyle advice opportunistically. The practice had performed in line with the local CCG average for their smoking cessation success rate, achieving 45% of their target.
- The practice hosted a psychological therapy service once weekly.

The practice had a failsafe system for ensuring results were received for every sample sent as part of the cervical screening programme. The practice's uptake for the cervical screening programme was 77% for 2014/15, which was comparable to the CCG average of 83% and the national average of 82%. There was a policy to offer telephone and letter reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and provided telephone reminders to non-attenders.

Childhood immunisation rates for the vaccinations given were above or in line with CCG averages for 2014/15. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 98% and five year olds from 85% to 97%, which were all above CCG averages. Benchmarking data for 2014/15 showed that the practice were the second highest performing practice in the CCG for the five in one vaccine for those under 12 months, achieving 98%.The practice were the highest performing in the CCG for the pre-school booster, achieving 92% compared with CCG average of 63%, despite the practice having a higher than average number of children under 5 years. The practice promoted uptake by monitoring those who missed immunisations via phone call and letter and proactively asked parents and guardians of all newly registered children to bring the immunisation records due to the large number of patients from abroad.

Flu vaccination rates for the over 65s were 63% which was below national average, and flu immunisation rates for at risk groups was 51% for 2013/14 which was in line with the national average. Immunisation rates for over 65s had improved to 65% for 2014/15 and for at risk groups it had increased to 58%. Patients with diabetes who had received the flu vaccination was at 84% for 2013/14 which was lower than the national average of 94%. The practice had worked to promote the uptake of flu immunisations by providing Saturday flu clinics and providing these opportunistically.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. The practice were pro-active in making use of new patient health checks to screen patients with complex conditions, due to the high prevalence of diabetes, especially in their Asian population. They had completed 876 new patient checks in 2014/15, with only a small number of registrants who had declined. The practice had completed 100% of annual health checks for their 17 patients with a learning disability in 2014/15. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people 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 that 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 36 patient CQC 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. Patients felt that the reception staff were friendly and helpful and that GPs were patient and took the time to listen to them. Patients reported that the practice provided an excellent service, particularly for Tamil patients.

We spoke with 10 patients during the inspection and one member of the practice's Patient Participation Group (PPG). All patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

We also spoke with one member of the PPG. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was 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 mostly in line with local and national averages for satisfaction scores on consultations with doctors and nurses. For example:

- 76% describe the overall experience as good compared with a Clinical Commissioning Group (CCG) average of 79% and a national average of 85%.
- 81% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 78% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 80% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 85%.
- 79% said the nurse was good at listening to them compared to the CCG average of 88% and national average of 91%.
- 78% said the nurse gave them enough time compared to the CCG average of 88% and national average of 92%.
- 94% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96% and national average of 97%.
- 77% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 70% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received and staff took time to explain their medical care. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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:

Good

Are services caring?

- 88% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.
- 80% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 90%.
- 75% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and this notice was also available in Tamil.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations, including information in Tamil.

The practice did not have an up to date carers register. We were told that this was in the process of being updated. The practice reported they knew their population well and were able to provide support to known carers. Written information was available to direct carers to the various avenues of support available to them. We were shown three compliment letters commending the practice for their support and two letters reported that the practice had been accommodating to meet the needs of family members acting as carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them and they were sent a letter of condolence with home visits or appointments at the practice where required. Advice on how to find a support service was also provided and there was information relating to bereavement support available in Tamil.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

One of the partners attended the local Clinical Commissioning Group (CCG) meetings on a regular basis. The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, practice patients had access to the local healthy living advisory service that took place once a week in the surgery. The practice had taken part in a local CCG pilot initiative for Winter 2014/15 to provide improved emergency access to appointments for children, to reduce Accident and Emergency (A&E) attendances.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example:

- The practice offered extended hours on a Monday, Tuesday and Wednesday evening from 6.30pm until 8pm and Saturday from 9.30am to 12.30pm which suited working patients who could not attend during normal opening hours.
- Urgent access appointments were available daily with each GP for all children, older patients, those at risk of admission to hospital and those with serious medical conditions.
- There were longer appointments available for patients who needed extra support such as people requiring translation, people with dementia and those with a learning disability.
- Home visits were available for older patients and housebound patients who would benefit from these.
- The practice was able to register homeless patients and temporary patients.
- All staff were aware of the most vulnerable and at-risk patients registered with the practice. The practice held a register of vulnerable children, vulnerable adults, housebound patients and those at risk of unplanned admissions to hospital.
- The practice employed a practice pharmacist. The pharmacist was able to take part in joint reviews for patients including home visits and promoted patient understanding of their medicines. Additionally, the pharmacist assisted in ensuring new patients from overseas with existing medicines were prescribed the UK equivalents.
- The practice offered an over 75's health check and provided appointments for these patients at the practice. These patients received a review from the practice nurse and where appropriate, also from the GP and the practice pharmacist. Joint home visits would be completed by the GP and pharmacist if required.
- The practice offered shared care pre-natal services and hosted a midwifery service every two weeks.
- The practice were able to provide a full range of family planning services with the GPs or nurse practitioner.
- There were baby changing facilities and disabled facilities. Although a hearing loop was not available, one of the non-clinical staff members was able to communicate using sign language.
- There was significant support available for patients with language barriers. The practice had recognised that the majority of their practice population were from Tamil and Sri Lankan backgrounds. There were notices in Tamil in the waiting area and the website could be viewed in other languages. Twelve different languages were spoken amongst practice staff including Tamil, but a translation service was available when required. Two non-clinical staff members who spoke Tamil had been specifically trained to be a chaperone for this patient population. The practice provided a patient information leaflet in Tamil for new patients.
- The practice had tailored its service to ensure patient education was a priority, especially in vulnerable groups. The practice had worked with its staff to develop a range of patient information leaflets in Tamil. We were shown a range of information including detailed leaflets for diabetes, dementia and breast feeding. The practice reported they had shared their information leaflets with other local health services to support Tamil patients. The practice website included specific health information advice for the practice population, for example, advising those patients from an Asian background planning a pregnancy to be checked for sickle cell disease.
- The practice had a high prevalence of diabetic patients; double the expected prevalence for the practice list size. This was due to a high incidence of diabetes in the Asian population. As a result of this, the practice had

published a book about diabetes in Tamil, to specifically target those with a risk of uncontrolled diabetes. This was provided to assist patients with improved self-management and improved awareness of diabetes amongst the practice population. The practice had also trialled a Saturday morning education session for Tamil patients for long-terms conditions such as diabetes.

- As the practice had a large population of potentially vulnerable patients registering with the practice from overseas, health checks were completed for all new patients where medical problems such as diabetes and mental health concerns could be flagged. This was also used as an opportunity to educate patients. The health care assistant was able to communicate in Tamil and frequently provided patients with the Tamil information leaflets during these health checks.
- The practice were able to signpost patients to a local temple where patients were able to access health education talks from Tamil speaking doctors, for example, for mental health support.

Access to the service

The practice was open between 8am and 8pm Monday, Tuesday and Wednesday and between 8am and 6.30am on Thursday and Friday. Appointments were from 8.30am to 6.30pm daily. Extended hours surgeries were offered from 6.30pm to 8pm on Monday, Tuesday and Wednesday and from 9.30am to 12.30pm on Saturday. In addition to pre-bookable appointments that could be booked up to one month in advance, same day appointments were also available for people that needed them. Emergency appointments were also provided and these patients were either seen by the senior nurse or by GPs.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was in line or below local and national averages:

- 80% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 70% and national average of 75%.
- 52% patients said they could get through easily to the surgery by phone compared to the CCG average of 60% and national average of 73%.
- 61% describe their experience of making an appointment as good compared with a CCG average of 66% and a national average of 73%.
- 72% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.
- 41% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 55% and a national average of 65%.
- 34% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 50% and a national average of 60%.

However, there was evidence that the practice population were less satisfied in general compared with others in the CCG area, as satisfaction scores with out of hours services were among the lowest in the CCG area, although all patients across the CCG received treatment from the same out of hours service.

The patient survey data did not clearly align with the views of patients we spoke with or with comments cards received. People told us that they were able to get appointments when they needed them. We found that pre-bookable appointments were available within 24 hours. Emergency appointments were always provided where needed, especially for vulnerable groups, which was supported by comments received from patients. Patients told us that appointment availability had improved and patients found it easy to make appointments, especially using the online booking service. However, a small number of patients we spoke with did report appointments were often delayed. Staff told us that delayed appointments were the result of the time required to ensure that patients were understood and involved in their care, due to the majority of patients with language barriers.

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.
- 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 including a complaints poster, information on the practice website, information on the practice leaflet and an additional detailed complaints leaflet.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 15 complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way and there was openness and transparency with dealing with the complaint etc. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, the practice had identified during their six-monthly complaint meetings that there was a theme relating to medicines incidents, specifically prescribing. These complaints were linked to similar themes from significant events. We found evidence that the practice's prescribing policy had been updated as a result and that a meeting had been held specifically to share the new prescribing policy and procedures with relevant staff.Although the practice had complaints meetings, the complaints folder and meeting minutes contained minimal evidence of what was discussed and whether previous actions had been completed.

The themes arising from complaints were shared with the Patient Participation Group.

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 discussed their vision and strategy with staff and all staff we spoke with were aware that the practice was looking towards better ways of working by integration with local GP practices whilst maintaining continuity of care for patients and also a vision to improve Quality and Outcomes Framework data. The practice did not have their vision and strategy formally documented in a business plan.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Governance structures and procedures in place included:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff on the practice's shared drive or they were in foldersm including a folder for reception staff. Not all staff knew how to locate policies if they needed them and on the inspection day there was difficulty locating requested policies. A number of policies we viewed had all been updated to reflect any changes in governance, but practice information was not clearly structured. The new senior administrators in the practice were in the process of re-organising the practice records to make policies more accessible and there was some evidence that changes had been made.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice had identified most risks to patient and staff safety such as infection control, however some health and safety risks had not been followed up such as those related to asbestos. Systems for recording incidents and complaints were in place with evidence that systems had been improved as a result. Complaints and significant events meetings were held to identify themes that arose, but it was not always clear how the practice ensured actions were monitored.
- Systems for monitoring and recording staff training were not clear. Some training evidence was visible in staff files, recorded in meeting minutes, or in a training log, but there was no clear overview of all training completed by staff.
- There was a comprehensive understanding of the performance of the practice. The partners attended Clinical Commissioning Group (CCG) meetings where performance data was shared. The two GP partners met with the practice manager monthly to discuss practice performance and to identify areas for improvement. However, minutes of these meetings were not kept in order to monitor actions.
- Clinical audits were used to monitor quality and to make improvements, by linking audits to practice performance; however a clear clinical audit plan had not yet been developed.

Leadership, openness and transparency

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents:

- The practice gives affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of written correspondence.

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice held administrative team meetings every three months but these had recently been increased to a weekly basis.
- The practice held meetings for all staff every three to five months and were saw that comprehensive minutes of these meetings were kept.

Are services well-led?

Good

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

- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.
- All staff received annual appraisals and personal development plans.
- All staff received a total of five days study leave per year and all staff had completed training according to their development needs.
- Staff said they felt respected, valued and supported, particularly by the partners and the practice manager. 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.

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.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG of 11 members which met on a quarterly basis, carried out patient surveys and submitted proposals for improvements For example, the practice had implemented a new telephone system in 2014 to improve telephone access and to allow a telephone queuing system following patient survey data. They also employed a new reception staff member and allocated one receptionist to be just answering phones and one to deal with face-to-face queries. Previous improvements made in conjunction with the PPG included improved front access to the surgery and promotion of online access to appointments. The PPG were currently involved with the submission of a grant application and plans for current premises improvement.
- The practice had also gathered feedback from staff
- The practice gathered feedback from the NHS Friends and Family Test (FFT), compliments received and suggestions. There were three suggestions boxes available in the reception area.
- There was information about the PPG in the waiting area and patients could download an application form online. PPG survey results were displayed on the practice's website.

Continuous improvement

There was a strong focus on continuous learning and improvement. The practice team was forward thinking to improve outcomes for patients in the area. For example, they had a practice pharmacist that had been employed for over 10 years, who assisted in improving patient outcomes through joint working with clinicians, which had specifically benefited the over 75s health checks and monitoring new patients from abroad with existing medication.

The practice had also been pro-actively seeking to promote self-management for patients with long-term conditions by tailoring patient information to those patients from a Tamil background.