

Dr AK Sinha's Medical Practice

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall. (In January 2018, the practice was previously rated Good, with requires improvement in providing safe care and treatment.)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We previously carried out an announced comprehensive inspection at Dr AK Sinha's Medical Practice on 3 May 2017. The overall rating for the practice was good with requires improvement in safe. Breaches of legal requirements were found and requirement notices were served in relation to safe care and treatment and recruitment. We carried out an announced focused inspection at Dr AK Sinha's Medical Practice on 3 January 2018 to check that the previous breaches had been met. At that inspection we rated the practice good overall with requires improvement in safe. Breaches of legal requirements were found and a requirement notice was served in relation to good governance. The full comprehensive report on the May 2017 and January 2018 inspections can be found by selecting the 'all reports' link for Dr AK Sinha's Medical Practice on our website at www.cqc.org.uk.

We carried out an announced comprehensive inspection at Dr AK Sinha's Medical Practice on 6 November 2018 to follow up on breaches of regulations.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Staff had completed appropriate safeguarding training. Safeguarding policies did not support staff in

safeguarding patients at risk of abuse from female genital mutilation. The practice had not reconciled their children's safeguarding register with the health visiting team.

- Systems for acting on Medicines and Healthcare products Regulatory Agency (MHRA) alerts had been put in place.
- Staff recruitment checks had improved following our previous inspection.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines. However, guidelines for the treatment of patients with gestational diabetes or patients with gout needed to be reviewed.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they could access care when they needed it.
- There was continuous learning and improvement at all levels of the organisation and the practice engaged with local Clinical Commissioning Group initiatives.

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

- Reconcile safeguarding registers with the health visiting team. Update safeguarding policies and procedures to support staff in safeguarding patients at risk of abuse from female genital mutilation.
- Increase the percentage of medication reviews for patients on repeat prescriptions.
- Develop processes to embed historic Medicines and Healthcare products Regulatory Agency alerts into the practice's medicine monitoring systems.
- Review guidelines for the treatment of patients with gestational diabetes or patients with gout.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

Background to Dr AK Sinha's Medical Practice

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Dr AK Sinha's Medical Practice is a single-handed GP practice. It is located in Longton, Stoke-on-Trent and provides care and treatment to approximately 2,545 patients of all ages. The practice is a member of the NHS Stoke-On-Trent Clinical Commissioning Group (CCG) and provides regulated activities from this location only. It

holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.


The practice is in an area of high deprivation being in the second most deprived decile in the country. Demographically 27.6% of the practice population is under 18 years old which is higher than the national average of 20.8% and 10.7% are aged over 65 years which is below the national average of 17.1%. The practice supports a diverse community with 75% white British and 25% of people from other nationalities. The percentage of patients with a long-standing health condition is 55.8% which is comparable with the national average of 53.7%.

The practice staffing comprises of:

- One male GP.
- A female practice nurse.
- A health care support worker
- A practice manager.
- Four members of administrative staff working a range of hours.



GP telephone consultations are available for patients who are unable to attend the practice within normal opening hours. During the out-of-hours period services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.



The practice offers a range of services for example, immunisations for children, child development checks, travel vaccinations, lifestyle advice and management of long-term conditions such as diabetes. Further details can be found by accessing the practice's website at www.drsinhaandpartners.co.uk

Are services safe?

At our previous inspection on 3 January 2018, we rated the practice as requires improvement for providing safe services. This was because:

- The action taken in response to external Medicines and Healthcare products Regulatory Agency (MHRA) alerts had not been fully documented in the records of patients identified through the searches undertaken.
- Not all of the required staff recruitment checks had been obtained. For example, a full employment history, evidence of qualifications and information relating to any physical or mental health conditions prior to employment.
- There was no documentary evidence available to show that a locum GP had attended safeguarding vulnerable adults training.
- A formal process was not in place that enabled the practice nurse to task the GP where patient queries were identified. Where non-patient related clinical supervision issues occurred these were not recorded electronically to provide a clear audit trail.

At this inspection, we rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from the risk of abuse. However, systems to reconcile safeguarding registers with the health visiting team were not in place. All staff received up-to-date safeguarding and safety training appropriate to their role. At this inspection we saw documentary evidence demonstrating that a locum GP had attended safeguarding vulnerable adults training at an appropriate level. Staff knew how to identify and report concerns. Whilst staff were aware of their responsibilities in reporting concerns regarding female genital mutilation (FGM), safeguarding policies and procedures did not provide support or guidance.
- Staff who acted as chaperones were trained for their role and 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.)

- Staff took steps, including working with other agencies, to protect patients from the risk of abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. Professional registrations for GPs and nurses were in date however there was no formal system of checking this on an annual basis. Following our inspection, the practice forwarded to us evidence of the systems they had introduced to monitor this.
- There was an effective system to manage infection prevention and control. Non-clinical staff had not received immunisation against hepatitis B. However, interviews with staff on the day of our inspection demonstrated they had a sound knowledge of the actions to take to mitigate potential risks to themselves and patients. A formal risk assessment, including the recommendation for non-clinical staff to be provided with the appropriate vaccines, was forwarded to us the day after the inspection.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Non-clinical staff were aware of the red flags in recognising patients with possible sepsis and the action to be taken to ensure the patient was reviewed immediately by a GP.

Are services safe?

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

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.
- The practice nurse sent electronic tasks to the GP if they had questions relating to a patient consultation or prescription. The GP maintained dated hand-written records to ensure follow ups for patient blood tests and appointments were actioned and followed up.

Appropriate and safe use of medicines

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

- The practice was above the local and national averages for the prescribing of sleep enhancing medicines. We discussed this with the GP who told us this was due to high levels of depression and anxiety within the practice population.
- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Since our previous inspection, the practice had introduced systems for handling Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts. Most MHRA alerts had been acted on however, systems to embed historic alerts into the practice's everyday medicine monitoring systems were not fully established.

- Staff prescribed and administered medicines to patients and gave advice on medicines in line with current national guidance. The GP had oversight of the practice nurse's prescribing activity and reviewed consultations with her. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up appropriately. However, at the time of our inspection only 45% of medication reviews for patients on repeat prescriptions had been completed.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learnt and made improvements when things went wrong.

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

Please refer to the evidence tables for further information.

Are services effective?

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Protocols for the care of patients with long-term-conditions reflected current National Institute for Health and Care Excellence (NICE) guidelines. However, the practice needed to review guidelines for the treatment of patients with gestational diabetes and patients with gout.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 75 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up older patients discharged from hospital and worked with the Clinical Commissioning Group (CCG) to try to reduce the number of unplanned hospital admissions. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Patients over 75 years old were offered annual health checks. The practice had completed 96% of these health checks during 2017/18. Any issues identified were discussed at meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals.
- The practice nurse provided domiciliary flu vaccinations to older housebound patients.

- The practice was proactive in providing support to patients at risk of unplanned hospital admissions.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected high blood pressure were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The percentage of patients with diabetes, on the register, in whom their blood glucose readings were in line with recognised parameters in the preceding 12 months was below the local and national averages. We spoke with the GP who explained they were aware of this and had taken action to try to address it. For example, the practice nurse worked with patients to deliver the DESMOND programme. The DESMOND programme is the collaborative name for a family of group self-management education modules, toolkits and care pathways for people with, or at risk of, diabetes.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above apart from the uptake rate for under one-year olds which was slightly below this target. We spoke with the practice nurse who told us that if a child failed to attend for their immunisations they wrote to the parents of the patient and if necessary liaised with the health visiting team.

Are services effective?

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 68.1%, which was below the 80% coverage target for the national screening programme. The GP and practice nurse told us that to encourage patients to attend for screening the practice rang or texted patients the day before their appointment. Alerts were also added to the records of patients who had not attended for their screening to prompt clinicians to discuss this at any future consultations.
- The practice's uptake for breast screening was comparable with the national average. However, their uptake for bowel cancer screening was below the national average. The practice told us patients were reluctant to engage in this screening.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including housebound patients, patients with no fixed abode, carers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with a learning disability were offered an annual review. Any issues identified were discussed at meetings with the ILCT to ensure the most appropriate team member provided the support the patient needed.
- Staff received refresher training in caring for patients with a learning disability.

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

- The practice worked with secondary care specialists to assess and monitor the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to collect prescriptions for long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice nurse was in the process of identifying additional support services for patients with dementia.
- The practice offered annual health checks to patients with dementia.
- The practice's performance on quality indicators for mental health was in line with local and national averages.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The practice's overall exception rate was below the local and national averages.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, screening patients from countries with a high rate of tuberculosis and reducing unplanned hospital admissions.

Effective staffing

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

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long-term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals and revalidation.

Coordinating care and treatment

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

- Records demonstrated that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. For example, the palliative care team.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions. They shared information with, and liaised, with community services, social services and carers for housebound patients.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example dietary programmes for patients with diabetes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice nurse obtained written consent from parents or guardians prior to administering childhood immunisations.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for all questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given).

- Staff communicated with people in a way that they could understand. For example, for patients whose first language was not English the practice had access to a telephone translation service and the GP spoke Urdu.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's GP patient survey results were in line with local and national averages for all questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patients' needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice maintained a register of older housebound patients who were visited six monthly or earlier if required. The practice nurse visited these patients on an annual basis to complete or update a patient's care plan.
- To support older patients to stay fit and healthy in their own homes, the practice nurse offered a home visit to all patients over 85 years old.

People with long-term conditions:

- Patients with a long-term condition received an annual review with the practice nurse to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment where possible, and consultation times were flexible to meet each patient's specific needs.

- The practice held regular meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child aged five and under were offered a same day appointment when necessary.
- A sexual health and contraceptive service was available for young adults at the practice.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online booking of appointments and ordering of repeat prescriptions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including housebound patients, patients of no fixed abode, carers and those with a learning disability.
- Patients with a learning disability were offered appointments at the end of surgeries when it was quieter.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- A counsellor from Healthy Minds visited the practice one day a week to support patients experiencing poor mental health.

Timely access to care and treatment

Are services responsive to people's needs?

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.
- The practice worked with the North Staffordshire GP Federation to provide patients with access to appointments outside of normal working hours.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was readily available to patients on the practice website and in the reception area.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. However, we found that complaint records were stored in patient records. Before the end of the inspection, the practice manager printed off the complaints and stored them in a separate file.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and, with the support of the patient participation group (PPG), were exploring ways of addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population. For example, the practice had participated in a service to screen patients from countries with a high rate of tuberculosis.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. For example, a receptionist had been supported to train to become a health care support worker. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. We saw risk assessments had been completed to mitigate identified risks to staff.
- The practice actively promoted equality and diversity. Staff felt they were treated equally.
- There were positive relationships between staff and the management team.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

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

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was some evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in clinical and team meetings where staff had sufficient access to information.
- The practice used performance information which was reported and monitored both internally and externally by the Clinical Commissioning Group.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, ambulatory blood pressure monitoring.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active PPG. The practice had worked with the PPG to canvas patient opinion regarding a possible merger with a nearby GP practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Non-clinical staff had received nationally recognised training in care navigation to support the workflow throughout the practice. The practice manager audited this work to monitor that it was effective.
- The practice had worked with the CCG to deliver enhanced services to patients. The practice was in discussion with the CCG to host a link worker at the practice to facilitate social prescribing.

Please refer to the evidence tables for further information.