

# Dr Kanwalpal Nandra

## 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?		Good	
Are services well-led?		Requires improvement	

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8

### Detailed findings from this inspection

Our inspection team	9
Background to Dr Kanwalpal Nandra	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kanwalpal Nandra's practice on 12 August 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had identified risks and had implemented systems to mitigate risks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- We saw that outcomes for patients were in line with national standards.
- Regular multi-disciplinary team meetings were in place at the practice.
- The practice provided extended access on Monday evenings and had adapted the practice to meet the needs of all patients.
- 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.
- Governance arrangements were in place at the practice, but in some instances outcomes of meetings and policies and procedures were not documented.

The areas where the provider should make improvements are:

- Ensure that clinical meetings at the practice are minuted.
- The practice should ensure that all policies and guidance at the practice are specific to the practice.

# Summary of findings

- The practice should ensure that planned measures to change the flooring in the clinical rooms in the practice takes place as soon as possible.
- The practice should ensure that fire tests and drills are carried out and a record of these checks is maintained.
- The practice should ensure that it proactively seeks feedback from patients and that it meets regularly with the patient participation group.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

The practice had systems and facilities in place to ensure safe care.

Good



### Are services effective?

The practice is rated as good for providing effective services.

Data showed patient outcomes were in line with the average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used them routinely. Patients were assessed and their care was planned in line with current guidelines, including assessment of capacity and providing patients with health promotion advice.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good at providing caring services.

Patients that we spoke to and feedback from both CQC comment cards and the national patient survey showed that patients felt they were treated with dignity and respect. They also reported that they felt listened to and were involved in decisions relating to their care. We observed that staff at the practice knew patients well and treated them with kindness and respect.

Information for patients about the service on posters, in the practice leaflet and on the website was easy to understand.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Good



# Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

The practice is rated as requires improvement for being well led.

The practice had a clear vision and strategy but not all staff were aware of this. The leadership structure was clear and staff said they felt comfortable approaching managers with issues. The practice had policies and procedures in place, but they had not been adapted from templates in some cases. Governance in the practice was developed in some areas, but the practice did not have formalised clinical meetings in place. The practice did not proactively seek feedback from either staff or from patients. A patient participation group had been set up but did not meet regularly.

**Requires improvement**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for providing care for older people. The practice had named practitioners for all patients over the age of 75, and offered personalised care. It was responsive to the needs of older people and offered home visits. The practice had a policy of checking blood pressure and weight on a yearly basis. There was also an admissions avoidance plan in place at the practice which involved working with patients so that they could better care for themselves.

Good



### People with long term conditions

The practice is rated as good for providing care to people with long term conditions. The nurse led reviews of patients with long term conditions and there were recall systems in place to ensure that patients were reviewed on a yearly basis. Where appropriate care plans were developed at reviews. For those patients with multiple conditions, longer appointments were available. The practice worked closely with healthcare professionals in the community to provide care for these patients.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were safeguarding processes in place at the practice and children who were potentially at risk could be identified. The practice provided immunisations and uptake was in line with national averages. Appointments were available for children outside of school hours and the premises were suitable for children. This included a play area in the waiting room for very young children. We saw good examples of joint working with healthcare providers in the community.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was open later on a Monday evening to ensure that patients could attend out of hours. Telephone consultations were also available for this group. The practice website contained relevant information for patients in this group, and both appointments and prescriptions could be organised online.

Good



# Summary of findings

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of patients whose circumstance might make them vulnerable. The practice held registers of patients with learning disabilities and for patients who were housebound. Both groups of patients were reviewed on a yearly basis and in the past year the practice had provided health checks for all of its patients who had learning disabilities. Extended appointments were also offered. Homeless people and travellers could register at the practice.

The practice met every six weeks with district nurses, health visitors and the palliative care team to provide care for these patients. Staff that we spoke with 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.

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 86% of people experiencing poor mental health had received an annual physical health check. The practice had registers of patients experiencing poor mental health and those with dementia.

The practice had provided patients and carers with information about support groups, and details of these groups were advertised in the waiting room. A system was in place to recall any patients with poor mental health who had not attended appointments. Staff had received training on how to care for people with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

The latest national GP patient survey results showed the practice was performing in line with local and national averages.

- 60% find it easy to get through to this surgery by phone compared with a CCG average of 61% and a national average of 73%.
- 79% find the receptionists at this surgery helpful compared with a CCG average of 81% and a national average of 87%.
- 68% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 54% and a national average of 60%.
- 78% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 79% and a national average of 85%.
- 90% say the last appointment they got was convenient compared with a CCG average of 89% and a national average of 92%.

- 61% describe their experience of making an appointment as good compared with a CCG average of 64% and a national average of 73%.
- 90% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57% and a national average of 65%.
- 71% feel they don't normally have to wait too long to be seen compared with a CCG average of 51% and a national average of 58%.

As part of our inspection process we asked for CQC comment cards to be completed by patients. We received 10 comment cards. All of the cards commented that the staff in the practice were helpful, and the majority reported the service they had received had been good. Several patients commented positively on the individual care they had received.

We spoke to three members of the practice's Patient Participation Group (PPG) and eight other patients. All stated that the service provided by the practice was good. These findings were in line with the national GP patient survey and CCG and national averages.



# Dr Kanwalpal Nandra

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a GP specialist advisor and an expert by experience.

## Background to Dr Kanwalpal Nandra

Dr Kanwalpal Nandra's practice, also known as Bulbanks Medical Centre, is in Erith in the London Borough of Bexley. The practice has one practice principle who manages the practice which is based at a single site. The practice is based in a converted house which has been modified to ensure that it is fit for clinical use.

The practice provides primary medical services to approximately 3,400 patients. The practice employs one salaried GP. The GP principle is lead for most areas in the practice. Both GPs in the practice are male. The practice also employed a practice nurse, a practice manager, a practice administrator and five part time receptionists. At the time of the inspection visit the practice was looking to recruit a part time healthcare assistant.

The practice is contracted to provide Personal Medical Services (PMS) and is registered with the CQC for the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services, family planning, surgical procedures, and diagnostic and screening procedures at one location.

The practice provides a number of enhanced services, including childhood vaccinations, extended opening hours, influenza immunisations, learning disabilities, minor surgery, and rotavirus and shingles Immunisation.

The practice is open from 8:00am until 7:30pm on Mondays, from 8:00am until 6:30pm on Tuesdays, Wednesdays and Fridays and from 8:00am until 1:00pm on Thursdays. A local Bexley co-operative provides services to patients who need to see a practitioner between 1:00pm and 6:30pm on Thursdays. Outside of normal opening hours the practice used a Bexley based out of hours provider.

## Why we carried out this inspection

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

## How we carried out this inspection

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)

# Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and Bexley Clinical Commissioning Group (CCG) to share information about the service. We carried out an announced visit on 12 August 2015. During our visit we spoke with patients and a range of staff which included

GPs, practice manager, nurse, and receptionists. We spoke with eight patients who used the service, and received comment cards from a further 10 patients. We reviewed the personal care or treatment records of patients and observed how staff in the practice interacted with patients in the waiting area.

As part of the inspection we reviewed policies and procedures and looked at how these worked in the practice.

# Are services safe?

## Our findings

### Safe track record and learning

There had not been a large number of serious events, but the practice had adopted an open approach in managing these issues. Only two serious events had occurred since the beginning of 2014 and both were of a minor nature. However there was evidence of lessons being learnt from events in 2013 and patients had been apologised to where necessary. Staff were aware of escalation processes in the practice and told us that they would speak to the practice manager in the first instance if a serious event occurred.

The practice held multi-disciplinary team meetings every six weeks with district nurses, health visitors and members of the palliative care team. These meetings were minuted with action points highlighted when necessary. The clinical staff met every two or three days to discuss care. The practice staff reported that in these meetings they discussed National Institute for Health and Clinical Excellence (NICE) guidelines. An example was provided that the follow up of patients with diabetes had been discussed in the last week.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems and processes in place to keep people safe. All staff were aware of these processes. Examples included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice in the waiting room advertised to patients that the practice nurse could act as a chaperone. The nurse had received chaperone training and a Disclosure and Barring Service (DBS) check. At the time of our inspection, the practice nurse was the only member of staff acting as a chaperone. However, the practice had plans in place to train two reception staff and to ensure they received a DBS check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were some procedures in place for monitoring and managing risks to patient and staff safety. All electrical equipment had been checked in the last year, and clinical equipment had been calibrated to ensure that it was working well. The practice had a fire evacuation policy in place, but there were no records of fire alarm tests or fire drills being carried out. The practice had a number of other risk assessments in place including legionella, infection control and control of substances hazardous to health.
- We observed the premises to be clean and tidy. However, the GP consultation rooms were carpeted and the treatment room had a crack on the floor, both of which were potentially an infection risk. There were plans to replace the flooring in these rooms, but in the meantime the rooms were clean. The practice nurse was the infection control lead, and they had completed infection control audits regularly.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice nurse conducted audits of medicines stored on site, and there were appropriate cold chain procedures including temperature monitoring. Patient centred audits were carried out in conjunction with the CCGs medicines management team to ensure prescribing was in line with best practice guidance. Prescription pads were checked in and out and recorded as appropriate and were securely stored.
- Recruitment checks were carried out and the three staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. Administrative staff had not been subject to a DBS check because they did not act as chaperones, but all clinical staff had been DBS checked. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed

## Are services safe?

to meet patients' needs. If members of staff in the practice were on annual leave or they were unwell, cover was provided by locums and other staff working overtime.

### **Arrangements to deal with emergencies and major incidents**

The practice had panic buttons in place that could be used in the event of an emergency. Staff knew what action to take in the event of a patient being taken seriously unwell in the practice. There were emergency medicines available in the treatment room including an anaphylaxis kit. The

practice had oxygen available with both adult and children's masks but at the time of the visit there was not a defibrillator on site. However, the practice manager provided evidence to show the practice had put a defibrillator in place the week after the visit. All staff had received basic life support training in the last six months, and they all knew where emergency drugs could be found. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan in place including reciprocal arrangement with a local practice if the building became unfit for use.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We saw that all clinicians in the practice had attended update courses and that the lead GP met regularly with pharmacy advisers. There were regular clinical meetings at the practice, but these were not formal or minuted. As such, although the practice monitored guidelines there were limited mechanisms to show they had done so.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 538 out of a total of 559 with 5% exception reporting. The practice reviewed QOF data throughout the year to ensure that follow ups were managed and to improve outcomes for patients. Data from QOF showed that the practice had scored the maximum available for the management of patients with learning difficulties, dementia and poor mental health.

The practice was not an outlier for any QOF clinical targets. Data from the last year showed that:

- Performance for diabetes related indicators was similar to the CCG and national average.
- Performance for hypertension related indicators were in line with national averaged.
- Performance for mental health related indicators was better than the national average. This included patients with schizophrenia, and those with dementia.

The practice had undertaken clinical audits to demonstrate quality improvement. All of the clinical staff in the practice had been involved. There had been four clinical audits completed in the last two years. Following an anticoagulation audit, two of the patients reviewed as part of the audit had been recalled so their medicines could be

reviewed. The practice was in the process of repeating the audit to demonstrate improvement in outcomes. The practice participated in applicable local audits and national benchmarking.

### Effective staffing

Staff that we spoke to were aware of their responsibilities, and they had the knowledge and skills to deliver effective care and treatment.

- An induction programme was in place at the practice. We spoke with a new member of staff who confirmed their induction had included training on safeguarding, health and safety and confidentiality.
- Appraisals had only been introduced to the practice in the last year. At the time of the inspection only two of the non-clinical members of staff had received an appraisal but all others had an appraisal date scheduled. The practice manager regularly met with staff at the practice. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- Staff at the practice had received training on safeguarding, basic life support and information governance awareness. The practice manager kept a training matrix so that they could review progress against mandatory training. The practice used a mixture of in house training and e-learning modules.

### Coordinating patient care and information sharing

The practice's record system provided access to the tools necessary to plan and deliver care and treatment, including sharing information with and receiving information from other healthcare providers. This included care plans and risk assessments. Discharge summaries were received electronically and there were systems in place to ensure that follow ups could take place if the named doctor was away from the practice. All referrals were made by way of a dedicated administrator in the practice, and cover arrangements were in place in her absence.

We saw evidence that multi-disciplinary team meetings took place every six weeks at the practice. District nurses, health visitors and representatives of the palliative care team attended these meetings. We saw that care plans were discussed at these meetings.

# Are services effective?

(for example, treatment is effective)

## Consent to care and treatment

Patients' consent for care was sought by the practice in line with relevant guidelines. Care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance.

## Health promotion and prevention

The practice provided health promotion and preventative advice to its patients. There were posters and leaflets in the reception area, and there were boards that provided information such as how to access support groups. The practice had systems in place to ensure that patients who required extra support could be identified. For example, the practice kept a list of all patients who had been diagnosed with cancer, and a separate list of those with a terminal diagnosis.

The practice had a comprehensive screening programme in place. The practice's uptake for cervical smears in the last year was 83%, compared to 82% nationally. The practice had reminders on the patient record for those patients attending who had not had a cervical smear in the last five years.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 68.4% to 84.2 % and five year olds from 70.0% to 78.6%. Flu vaccination rates for the over 65s were 71%, and at risk groups 60%. These were also comparable to CCG and national averages.

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 followed up patients for health assessments, and information on the assessment showed that 93% of the practice's diabetic patients had received a health check in the last 12 months.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

During the inspection we noted that staff spoke to patients with respect and compassion. We noted that reception staff were familiar with many patients at the surgery and had established a rapport when speaking to them. All of the patients we spoke with commented that staff in the practice were warm and helpful.

All of the 10 patient CQC comment cards we received were positive about the service experienced, and three detailed positive, individual care. We also spoke to eight patients during the inspection visit. As with the comment cards, all were positive about the care they had received. Four of the patients that we spoke with said that the practice had been accommodating to them during periods of illness.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was in line with national and CCG averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 86% and national average of 97%.
- 88% said the GP gave them enough time compared to the CCG average of 83% and national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%.
- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 92% 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%.
- 79% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and national average of 87%.

### Care planning and involvement in decisions about care and treatment

The patients that we spoke with told us clinical staff at the practice were clear in their explanations and involved them in decisions in relation to the care they received. They told us that they considered that all clinicians in the practice listened to them and provided them with sufficient time to detail the background to any health concerns. Patient feedback on the comment cards was also positive in this regard.

The national GP patient survey also provided positive results, for example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 76% 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%.

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.

### Patient/carers support to cope emotionally with care and treatment

The lead GP told us that in the event of a family bereavement they would contact relatives to offer condolences, and would suggest that if they wanted to see him they could do so. He said that bereavement counselling was provided locally and the practice would refer patients if required. There were posters in the waiting room notifying patients of bereavement and carer support services.

The practice had a register of carers. Carers were offered yearly health checks and written information was provided to show what support was available to them.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice worked with the CCG to deliver targeted care to patients in the area. In particular the practice had recently started monitoring childhood obesity in children over the age of seven.

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

- Outside of the normal 8am – 6:30pm working hours the practice offered appointments until 7:30pm on Monday evenings for the benefit of working people.
- Double length appointments were available for patients with learning disabilities, those with multiple long term conditions and carers.
- The practice website provided information for patients, including the services available at the practice, health alerts and latest news. There was an up to date list of practice staff. Information leaflets and posters about local services, as well as how to make a complaint, were available in the waiting area.
- Home visits and telephone appointments were available to those patients who required them.
- The practice was accessible for wheelchair users, and there was a hearing loop in the reception area. Translation services were also available.

The practice had a patient participation group (PPG) in place, but the group did not meet regularly and had not met in the last six months. The practice manager said that she would instigate quarterly meetings with the group, but at the time of the inspection the group was not operating effectively.

### Access to the service

The practice is open from 8:00am until 7:30pm on Mondays, from 8:00am until 6:30pm on Tuesdays, Wednesdays and Fridays and from 8:00am until 1:00pm on

Thursdays. A local Bexley co-operative provides services to patients who need to see a practitioner between 1:00pm and 6:30pm on Thursdays. In addition to pre-bookable appointments which were available up to four weeks in advance, emergency slots were available every day. The lead GP reported that any patient who presented with an emergency would be seen on the same day.

The national patient survey showed that the practice was broadly in line with national and CCG averages in relation to accessibility:

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 75%.
- 60% patients said they could get through easily to the surgery by phone compared to the CCG average of 61% and national average of 73%.
- 61% patients described their experience of making an appointment as good compared to the CCG average of 64% and national average of 73%.
- 90% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57% and national average of 65%.

### Listening and learning from concerns and complaints

The practice had a 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 who was the practice manager. We look at three complaints received in the last 12 months and found they had been managed in line with these processes. The practice had not needed to make changes to the way services were delivered, but the practice manager said that they would do so if required.

The complaints system at the practice was advertised on a poster in the waiting area. However, the instructions on how to make a complaint were written in small writing on the notice. There was no information on the intranet about how to make a complaint.



# Are services well-led?

Requires improvement 

(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 statement of purpose in place and an objective of delivering high quality care for all while promoting good outcomes. However, the staff that we spoke to were not aware of it. The vision and the practice's values had not been discussed recently. However, the last time they had, which was over a year ago, they had discussed it with the patient participation group (PPG).

### Governance arrangements

The practice had an overarching governance framework in place which supported the delivery of good care. However, in some areas this framework was not formalised. Examples of this included:

- There was a clear staffing structure and staff were aware of their roles and responsibilities.
- Practice specific policies were in place in some cases. However, in others, the policies were templates that had not been adapted to the practice. This included policies for needle stick injury and zero tolerance to abuse.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

- The clinical meetings in the practice were not documented and minuted. As such we could not see how learning had been disseminated and how incidents had been discussed by the clinicians.

### Leadership, openness and transparency

Leadership in the practice was clear with the practice principle being lead for all clinical domains with the practice manager undertaking management of administrative staff. The practice staff reported that there was an open atmosphere at the practice and that they felt comfortable raising any issues of concern.

Staff told us that they felt respected and valued and that they were supported in the delivery of their work. All staff said that they could suggest ideas as to how the practice could be run more efficiently.

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

The practice did not seek feedback from patients in relation to how the practice was run. The practice had asked the PPG to contribute to the practice's vision and values, but meetings with the PPG had been limited and none had taken place in the last year. As such the only patient feedback received by the practice was through national patient surveys.

The practice had informally gained feedback from staff and there were occasional all staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.